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Helping battered women : a study of the relationship between nurses' education and experience and their preferred models of helping.

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HELPING BATTERED WOMEN: A STUDY OF THE RELATIONSHIP BETWEEN NURSES' EDUCATION AND EXPERIENCE AND THEIR PREFERRED MODELS OF HELPING

A Dissertation Presented

by

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ABSTRACT

HELPING BATTERED WOMEN: A STUDY OF THE RELATIONSHIP BETWEEN NURSES' EDUCATION AND EXPERIENCE AND THEIR PREFERRED MODELS OF HELPING

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The battering and abuse of women is a problem which adversely affects the health of millions of women in the United States. Nurses are in a particularly strategic position to identify and provide helpful interventions for women who come in contact with the health care establishment. The feminist literature argues for helping strategies which do not blame women for their abuse and which attempt to empower women to take control of their own lives. However, often the past educational preparation of the nurse has not included content on battering, leaving them unprepared to assess for

abuse or to provide intervention aimed at fostering independence and personal empowerment. The purpose of this study was to determine the perceived model of helping preferred by nurses in their interventions with battered women and to determine those factors in the nurses' educational experiences and clinical practice which affect their preference for a specific helping model. Data was obtained from 116 registered nurses, 57 nurses practiced in the emergency department setting, and 59 nurses had attended a three day national nursing conference on violence against women. The data of this study were collected through self-administered questionnaires: the Education/Experience Questionnaire and the Help Orientation Test.

The results of this study indicate that the medical model of helping, in which the client is attributed low responsibility for both problem cause and solution, not a particularly empowering model but one tending to foster dependency, is characteristic of the helping orientation of all nurses in the study sample. This is true regardless of practice setting, or whether or not nurses have acquired specific

knowledge on the topic of battering. All nurses reported significant clinical and personal contact with battered women but few reported having acquired specific education on battering. It was found that nurses who had acquired specific knowledge on battering did perceive themselves as knowledgeable and well prepared in their practice with battered women.

This research pointed to the relevance of the type of education about woman abuse which is necessary to permit nurses to not just help battered women but to help in such a way as to foster independence.

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HELPING BATTERED WOMEN

Introduction

The battering and abuse of women is a life threatening problem which adversely affects the health of millions of women in the United States each year. Current statistics indicate that over 3 million women a year are beaten or abused by male partners (Straus, Gelles, & Steinmetz, 1980). One quarter of all murders in the United States are between family members; one-half of these are between husband and wife (Dobash & Dobash, 1979). When women are murdered, ninety percent are murdered by men, eighty percent are murdered at home, and seventy-five percent are murdered by a husband or lover (Jones, 1980).

In the past two decades those in the social sciences have been involved in an examination of the escalating problem of spouse abuse. Sociologists have recognized battering as a serious social problem (Gelles, 1980; Steinmetz & Strauss, 1974; Walker, 1979; Wolfgang, 1958); the criminal justice system is beginning to respond to

domestic violence as a crime; and legislators are enacting stronger domestic violence laws (U.S. Department of Justice, 1986). While other disciplines have begun to recognize the frequency and severity of battering, the health care disciplines have been slow to recognize the health implications of battering. Abuse remains virtually unrecognized by the health care system (Stark, 1979). Very few battered women who utilize health care facilities are accurately recognized and virtually none of the physical, medical, or psychosocial sequelae of abuse are identified. Yet it is within the domain of the health care system that most battered women consistently seek help. Research at Yale-New Haven Hospital (Stark, 1981) has demonstrated that battered women make multiple visits to health care facilities for general health problems that may be as much a part of their battering as physical injury but go unrecognized and unrelated.

Battering consists of a combination of physical injury, medical and psychosocial problems, and social consequences. It has been estimated that twenty to thirty-five percent of the women presenting to a hospital emergency department are abused women (Appleton, 1980; Stark, Flitcraft, & Frazier, 1979). Battered women comprise 30% of all rape victims (Roper, Flitcraft, & Frazier, 1979), 25% of obstetrical

patients (Helton, 1986), and 25% of the women who attempt suicide (Stark & Flitcraft, 1981). It has also been found that battered women comprise 30-50% of female psychiatric inpatients (Carmfen, Rieker, & Mills, 1984), and 40-50% of women with alcohol problems (Stark & Flitcraft, 1987).

The violence and abuse endured by these women victims results in both physical and emotional health problems which are acute and chronic in nature. Given the magnitude of the problem, the battering of women certainly constitutes a national health problem of major proportion. It is clearly the responsibility of the health professions to recognize the problem and provide effective and helpful interventions which are aimed at preventing the devastating and long term physical, social and emotional consequences of abuse. It seems only logical that the experiences battered women receive in the health care system, especially initial contacts, can influence their recovery from the physical and emotional consequences of abuse. However unless these interventions are effective they run the risk of immobilizing women in their abusive relationships and decrease the liklihood of their seeking help from any source in the future.

The Department of Health and Human Services in their 1985 Report of the Public Health Service Task Force on Women's Health Issues

recommended that biomedical and behavioral research be expanded to ensure emphasis on conditions and diseases which are unique to, or more prevalent, in women. The Surgeon General's Workshop on Violence and Public Health (October 27-29, 1985) recommended that a full range of coordinated health, mental health, legal and social services for victims of spouse abuse be available in every community, supported by a stable funding base. They further recommended that research on prevention, causality, treatment and intervention of spouse abuse be given high priority with the allocation of resources for this effort proportionate to the extent of the problem as compared with other health problems. This report also recommended that information on spouse abuse should be a component of the basic curriculum for the education of all health professionals, including nursing.

Background of the Problem

Feminist writers and the activists from the battered women's shelter movement have produced much of the literature on battering. This literature (Dobash and Dobash,1979; Fleming,1979; Gates and Chapman, 1978; Roy, 1977; Walker, 1979) contends that the battering of women is rooted in a sexist social structure that produces profound

inequities in roles, relationships, and resource and power distributions between men and women. Battering is seen as a crime primarily perpetrated against women and their children. They espouse a helping approach which avoids victim blaming and seeks to empower women to free themselves from their violent lives. They criticize the traditional social, legal, medical and nursing approaches which have been devised to assist battered women. They argue that these approaches merely serve to reinforce the cultural myths and stereotypes which blame women for their victimization and trap them in cycles of violence. They posit that battered women are not responsible for their abuse. Interventions which blame the victim and do not hold the abuser accountable for the violence are considered ineffective and inappropriate. The type of help which is seen as most effective must focus on empowering women to take control of their own lives and destinies. They further contend that approaches which place responsibility for resolving the problem of abuse into the hands of the helper provide only episodic assistance and ultimately serve to immobilize women, trapping them further in their abusive relationships. Only with the acquisition of knowledge, support and help in problem solving can battered women make the decisions and choices which will free them from their abusive relationships.

Role of Nursing

Nurses, by virtue of their frontline position in all sectors of health care, can be instrumental in providing crisis oriented and continuing professional intervention to abused women. Nurses are in a particularly strategic position in both the hospital and community to identify abused women and provide helpful and therapeutic interventions. Nurses provide the majority of the health care offered in emergency rooms and clinics. They are expertly trained to respond to individual crises particularly of a traumatic nature. However, often the past professional education of the nurse has not includedspecific content on spouse abuse. These nurses are therefore ill-prepared to perform the thorough assessment that would disclose battering. They are also not prepared to provide for the effective interventions which are necessary in order to aid abused women in their attempts to break the cycle of battering. This lack of professional preparation leads to infrequent identification and ineffective intervention with battered women (Flitcraft & Stark, 1981).

Nurses, as health care professionals, need to question the appropriateness of the help battered women receive from the healh

care system. The professional education and socialization of nurses often predisposes them to believe that it is within their domain to solve the client's problems. In addition to this role socialization, it is the cultural socialization that predisposes individuals to attribute blame to abused women for their victimization. From a reading of the literature on battering (Campbell, 1984; Dobash and Dobash,1979; Fleming,1979; Gates and Chapman, 1978; Roy, 1977) it can be posited that nurses would be more effective in their helping if they acted not out of a need to rescue the woman but out of a desire to empower women, fostering indedendence and personal growth rather than dependency.

Statement of the Problem

The physical and psychological abuse of women by their male partners is a serious, life threatening problem, which like rape and incest has long been hidden from public view. The feminist movement has been actively engaged in efforts to uncover women's lives, to make public that which has been private, to illuminate the injustices and inequities of all women's lives. Nurses by virtue of their frontline position and their sheer numbers in the health care system are often

the members of the health care team with the most contact with abused women.

However the interventions employed by nurses may not always be the most effective and may in fact foster dependency and self blame. Examples include interventions which originate from a belief that battered women are either responible for their abusive situation or contribute to their own abuse and approaches which attempt to rescue the woman from her abusive situation. Nurses who have specific knowledge and clinical experience with abused women may be more effective in helping battered women. This education and experience may serve to rid the nurse of cultural stereotypes and myths surrounding woman abuse, allowing them to employ interventions which ultimately result in empowerment for battered women. Educational preparation in this specific topic area might be an influence in the nurses' effectiveness in helping battered women.

An examination of the ways in which nurses help battered women is one step in building a foundation upon which to shape educational and clinical programs to improve the effectiveness of professional intervention. This research will examine the helping orientation of nurses towards abused women and explore the relationship between education and experience on their helping orientation.

Purpose of the Study

Nurses come in contact with battered women in a variety of clinical practice settings and are capable of providing significant intervention for these women. It was the interest of this study to explore how nurses help battered women and to examine what factors influence the help nurses render so that approaches might be designed to enhance the effectiveness of nursing intervention.

To this end, the purposes of this study were:

1. To determine the model of helping preferred by nurses in their interventions with battered women.
2. To determine those factors in the nurses education and clinical practice which are related to their preference for a specific helping model.

Research Questions

Specifically this study will address the following questions:

1. What is the helping orientation of nurses towards battered women?
2. What is the relationship between specific education on the topic of battering and the helping orientation of nurses towards battered women?
3. What is the relationship between clinical experience with battered women and the helping orientation of nurses toward battered women?

Hypotheses

The nature of the help that nurses provide battered women is important to successful intervention aimed at empowering women to take control over their own lives. The cultural stereotypes and myths surrounding both women's roles in our society and the nature of woman abuse are held by men and women alike in American society. Nurses may subcribe to these myths and base their interventions on a belief that battered women are responsible for their own abuse and are unable to manage their lives or find solutions to their problems. Because of

this nursing intervention might be focused on helping woman recognize the abusive situation they themselves have created or fostered. This intervention, delivered within the realm of the traditional health care delivery system, particularly nursing care delivered in the emergency setting, is aimed at providing immediate relief for client problems. In the health care setting it is the role of the health professional to identify the client's presenting problem and provide all necessary intervention, with a belief that it is the actions of the health professional that are the critical elements needed for problem resolution.

Nurses who have been educated on the topic of battered women may however subscribe to fewer myths, influencing the nurses' view of these women, holding her less responsible for her abusive situation. This specific education on battering may also foster intervention strategies aimed at empowering the women to solve their own problems, thereby influencing the model of helping preferred by these nurses. Education and experience are key factors which influence the nurses' ability to effectively assess and intervene with battered women. Nurses who feel well prepared in these areas may possess specific knowledge and experience on battering. These nurses may subscribe to fewer myths and utilize empowerment helping strategies,

thereby influencing the model of helping preferred by these nurses. This study therefore proposed the following hypotheses:

1. In helping battered women, Emergency Department Nurses will prefer an enlightenment model (Brickman, Rabinowitz, Karuza, Coates, Cohn, & Kidder,1982) of helping more than any other model.
2. In helping battered women, nurses who perceive their clinical knowledge level as high on the topic of battered women will prefer a compensatory model (Brickman et al,1982) of helping more than any other model.
3. In helping battered women, nurses who perceive themselves as well prepared in their practice with battered women will prefer a compensatory model (Brickman et al,1982) of helping more than any other model.

Definition of Terms

Battered Women:

Women who have been subjected to acts of physical and/or psychological violence and abuse by a man with whom she currently has or has had an intimate relationship.

Clinical Knowledge:

Clinical knowledge will be determined by a score on a seven point self-rating scale that addresses perception of clinical knowledge related to battering.

Well prepared:

For the purpose of this study, well prepared will be defined as nurses who score high on the following two scales located on the Education/Experience Questionnaire; able to readily identify battered women, and sufficient clinical skills to intervene effectively.

Models of Helping:

Helping is an interaction between a person needing help and a person able to give help with the desired outcome of resolving the problem presented by the person needing help. For the purposes of this study, help will be defined in terms of the four models of helping developed by Brickman et al (1982). (These models are further defined in Chapter 2). (See table 1).

Moral Model. Persons are held responsible for causing and solving their problem.

Enlightenment Model. Persons are held responsible for causing their problem but are not held responsible for solving that problem.

Compensatory Model. Persons are not held responsible for their problem but they are held responsible for solving that problem.

Medical Model. Persons are neither held responsible for causing their problem nor for solving their problem.

Table 1
Attributional Qualities of Four Models of Helping

Model	Degree of Responsibility	
	Problem	Solution
Moral	High	High
Enlightenment	High	Low
Compensatory	Low	High
Medical	Low	Low

Significance of the Study

The scholarly and practitioner literature concerned with battering was virtually nonexistent before 1960; prior to 1970 only two scholarly articles on wife abuse had been published in the professional journals. This may indicate professional disregard for this problem

despite its severity and the overwhelming number of helping professionals who frequently and regularly see clients who are abused in their intimate relationships.

The violence and abuse endured by battered women results in both physical and emotional health problems which are acute and chronic in nature. It is within the domain of the health care system that many women seek help for the physical and emotional effects of abuse. Nurses, by virtue of their frontline position in all sectors of health care, can be instrumental in providing crisis-oriented and continuing professional intervention to abused women.

Nursing has an important role to play in the prevention, detection, treatment and scholarly investigation into this major health concern. Because of the sheer numbers, the variety of practice locations, the numbers and variety of clients served, and the nature of the professions holistic practice, nurses are in an ideal position to take action to decrease the likelihood and effects of woman battering.

This research will investigate factors which influence the helping orientation of nurses in their practice with battered women. Research in the health care domain can provide another link in our efforts to eliminate violence against women and provide effective intervention to its victims. An examination of the model of helping perferred by

nurses will be a step in understanding how nurses help abused women. Knowledge about the helping orientation of nurses will influence efforts aimed at changing the practice of nursing through changes in education as well as focusing further research in this area.

CHAPTER 2

REVIEW OF THE LITERATURE

Introduction

For the purposes of this study three categories of literature will be reviewed. Literature and research in the area of battered women will be reviewed for the clinical focus of the study. Literature in the area of helping and in the field of Attribution theory will provide the theoretical framework. Attribution theory can be a useful framework for examining the nurse-client relationship because it is one of the few models which explicates victim blaming for the cause of the problem and discriminates between responsibility for problem solution.

Battered Women

Violence in the family is a common and serious health problem in the United States. Acts of violence occur against all family members but much more significantly against those members of the family with less power, the women, children, and the aged (Chapman & Gates, 1978).

These acts are predominently inflicted by male partners and heads of household (U.S. Department of Justice, 1986). This violence can be attributed to the sexist structure of society, in which men maintain power and control over women and children. Margaret Gates states that "this disparate power relationship has been recognized, sanctioned, and reinforced over time by all our social institutions" (Gates, 1978:11).

The possibility that any one of us might be injured or have our homes invaded by a stranger is frightening. But hundreds of thousands of women face a far more frightening and devastating reality, that they will be harmed by someone they love and trust. The battering of women by male partners strikes at the heart of our society and leaves the survivors suffering emotional and physical pain, fear of future and more life threatening attacks, and for some, death.

Those who are victims of woman battering often, if not usually, suffer these experiences alone. They are uniquely isolated as friends, family and professionals who might otherwise be a source of support hesitate to intrude on the privacy of the home and family. The idea that the battering of women is a rare event and perpetrated by a few mentally ill people is erroneous. There exists a general myth of family harmony and a cultural norm which depicts the family as a refuge of loving relationships. Yet legal experts believe that wife abuse is one of the most under-reported crimes, even more than rape. Wife beating

has been estimated to be occurring in one third to one half of all familial relationships (Gelles, 1980, Levinger, 1966, Walker, 1979).

Dobash and Dobash (1979) in their classic work on the victimization of women argue that much of the ideology and institutional arrangements which support patriarchy continue to exist in our culture. It is our socialinstitutions which serve to maintain a system which subordinates, dominates, and controls women. They remark that "wife beating is not, in the strictest sense of the word, a 'deviant', 'aberrant', or 'pathological' act. Rather it is a form of behavior which has existed for centuries as an acceptable, and, indeed, a desirable part of a patriarchial family system within a patriarchial society" (Dobash & Dobash, 1979:427).

In this light, the United States, as a male dominated society with most positions of power and influence occupied by men, continues to perpetuate a system of patriarchy. Violence is the ultimate tool to maintain power and control, with women the legitimate object for victimization. In our American culture, the violence directed by men against women serves to maintain control over women, to keep them at home, dependent, servile, and terrified of stepping out of the traditional role of wife and mother.

This violence affects every area of women's lives, it is perpetrated individually yet reinforced and encouraged institutionally by the failure

of society to recognize its presence and seek measures to prohibit its occurrance. The few statistics which are available, grossly underestimate the extent and severity of woman abuse and serve to maintain the illusion that a woman's private home is her safe sanctuary. The usual sources of statistical information, the police, courts, health care system, academic community, and social service networks, have failed to provide accurate documentation. This statistical silence is the result of a variety of cultural, legal and social practices which underscore a system of patriarchy (Dobash and Dobash, 1979). Wife beating is an accepted custom, practiced by many, tolerated by our social order, and the subject of much indifference and social humor.

Review of available research reports and statistics on criminal behavior indicate that it is in the marital and intimate setting that women are most likely to be the victims of violence. Homicide statistics reveal that relatives comprise the single largest category of murder victims and assault and domestic disturbance constitute the largest category of calls to police, exceeding the number of calls for all criminal incidents, including murder, rape, robberies and muggings (Martin, 1976; Strauss, 1977; Wolfgang, 1958).

The research directed at uncovering domestic violence clearly points to a differential nature of violence in which men are violent

towards female partners. This violence is usually persistent and escalates in frequency and severity (Roy, 1977).

Social scientists have provided the most research in the area of woman battering, examining the structural and cultural factors in American society which encourage wife beating. Gelles (1974) found that 54% of the 80 couples interviewed in his study had used physical force in their relationship and 25% indicated that violence was used with some regularity. Steinmetz (1977) examined 57 intact families and found that physical violence was reported as being used by 60% of the families.

Steinmetz and Strauss (1980) collaborated on a national study of domestic violence, surveying 2,000 couples, and confirmed their hypothesis that violence in American families was normative. One in six couples, representing 7 1/2 million marriages, experienced at least one violent episode in 1975. Twenty-eight percent of the subjects reported conjugal violence at least once in their marriage. They argue that this is probably an under-estimate as only couples living together were surveyed and divorced people were only questioned about their current relationship. These researchers suggest that a truer incidence would estimate that 50-60% of all couples, rather that 28%, had experiences with conjugal violence.

The only comprehensive national survey conducted was completed by Strauss and Associates (1977). A national probability sample of 2,143 persons (960 men; 1,103 women), representing all major demographic attributes of American families, were interviewed. The key findings of this research indicated that:

- Sixteen percent of the couples engaged in one of eight acts of violence, ranging from a slap, punch, use of knife or gun, during the survey.
- Twenty-seven percent of the couples engaged in acts of violence at some point during their marriage.
- Twenty-five percent of the respondents saw physical force between spouses as necessary, normal or good.
- One of every 200 couples had been involved in an incident in which a knife or gun had been used during the survey year.
- One of every eight couples had experienced high-injury-risk violence.
- Wives were victimized by violence to a much greater extent than husbands.
- A large number of the attacks occur when the woman is pregnant.
- Violence occurs frequently in all socioeconomic groups.

There is considerable variation in the definitions and social meanings of wife abuse and the battering of women. These definitions range from those which only include repeated violent acts resulting in serious injury to more comprehensive and global definitions which take into consideration emotional and psychological abuse as well as physical battering. Professionals elicit a variety of definitions which originate from the theoretical perspective of the professionals'

discipline. Physicians look for physical sequelae, sociologists focus on the milieu in which violence occurs, psychologists concentrate on the psychologic components and personality characteristics of the victim and assailant.

Synonyms for violence include physical assault, abuse, battering, brutality, aggression. Operational definitions include periodic slapping, pushing, shoving, which rarely escalates and is not intended to cause serious harm; repeated punching and kicking with the intent to cause injury and seriously intimidate the victim; to violence with intent to kill. Some authors include threat, force, coercion, and psychological abuse.

In any definition of violence, the effect on the victim and her responses to the violence are important. Duggan (1981) identifies a continuum of physical and psychological violence which begins with neglect and includes abuse, battering, torture, and ultimately murder. The physical abuse sustained by battered women includes malnutrition, starvation, exposure, rape, venereal disease, pain, bruising, lacerations, fractures, internal bleeding, organ rupture, head injury, immobility, physical impairment, stress related disorders, neurological deficits, coma and death (Duggan, 1981).

The psychological abuse sustained by women includes external reactions, internal reactions and psychopathology. Externally, women

become isolated, immobile, confused, chaotic, hostile, homicidal, suicidal and antisocial. Internally women live in fear and anxiety, exhibiting emotions of guilt, pain, rage, loss, grief, apathy, emotional abandonment and low self esteem. For some women, the result of prolonged physical and psychological abuse is psychopathology, manifested by depression, neurosis/psychosis, and personality disorders (Duggan, 1981). What remains as a key element in all definitions is that wife beating exists when the woman is in fear of a man's superior stregnth and violent behavior with no option for reversal, postponement or escape.

Research on Battering

The academic research and literature that has emerged in the field of wife abuse primarily focuses on the prevalence of the phenomenon (Gelles, 1980; O'Brien, 1974; Martin, 1976; Eisenberg & Micklow, 1976; Strauss, 1977) and psychological and sociological profiles of the abusive husband, the abused wife, and the relationship (Goode, 1971; Steinmetz & Strauss, 1974; Martin, 1976; Strauss, 1976; Roy, 1977).

Perusal of the literature on wife abuse shows that there is an overwhelming concern with the psychology and pathology of the victim and abuser. This research focuses on characteristics of the abuser and

abused, blaming drugs, alcohol, economic conditions and men's insecurities for their violent acts. Rarely in the literature are men held accountable for this abuse and certainly the literature offers no explanation of why women, who are even more economically pinched, earning 56% of what men earn, are not battering their husbands and male partners in significant numbers. This research frequently excuses men for their violent acts, citing loveless childhoods, often highlighting maternal deprivation. Yet rarely does this literature discuss why women, with similar loveless, empty and often physically and sexually abusive childhoods, turn their sense of loss and insecurity into self deprecation, not terrorization (West, 1979).

A significant number of the academic articles and research reports effectively convey the attitude that violence is perpetrated by irrational people who come from inadequate childhoods or extreme structural stress (Steinmetz, 1977; Strauss, 1977; Gelles, 1980). This representation serves to avoid the underlying issue of the power relations between men and women and blame women for their own victimization.

In a similar light, this literature typically examines the pathology of the woman, seeking to uncover her masochistic tendencies and passive personality elements. Provocation is highlighted as well as the element of prior experience, assuming that battered women emerge

from inadequate, violent childhoods and seek to duplicate their earlier battering experiences. A variety of categories and personality profiles have been developed supposedly to assist clinicians in identifying and treating battered women (Bell, 1977; Goode, 1971; Strauss, Gelles & Steinmetz, 1980).

In an early publication on wife abuse, Schultz (1960) identified three prevailing stereotypes regarding battered women which exist and serve to place the cause for violence on the victim. These stereotypes are that battered women are basically ill, sadomasochistic women; that battered women instigate assaults through antagonistic verbal behavior; and that they are very masculine, outspoken, domineering women who exploit and profit from their husband's passiveness and dependency. Other myths subscribed to include: very few women are beaten, and when they are abused it is rarely serious; battering only occurs in lower socioeconomic groups; battered women do not try to leave or seek help; battering occurs only to married women; abusive men are usually unemployed and from lovless childhoods.

These stereotypes and myths are frequently internalized by battered women (Walker, 1979; Campbell, 1984). Women are left feeling responsible for their own abuse, isolated from others, and embarrassed about their family situation and choice of male partners. Professionals who subscribe to these myths participate in victim

blaming, induce guilt, and hinder identification and successful helping for battered women (Rounsoville et al, 1978; Stark, Flitcraft & Frazier, 1979).

Recent research has attempted to dispel these myths and has demonstrated that battering is found at all socioeconomic and educational levels. It has been shown that woman abuse is not limited to a particular cultural, ethnic, religious, economic or educational group. It is perpetrated by both sober and intoxicated men, with or without a weapon. Two common factors do emerge: abuse is rarely an isolated event, violence tends to escalate both in frequency and severity, and; the victims are overwhelmingly women (Campbell, 1986; Dobash & Dobash, 1979; Star, 1978; Stark, Flitcraft, & Frazier, 1979; Walker, 1979).

Research has also shown that battered women fall within the normal range on personality tests and clinical measures. The overall profile suggests a woman who is normal in most areas but who often displays low self esteem, lack of self confidence, shyness and reserve when interacting with others, and a self critical stance. In these studies many of the women appeared anxious, and revealed considerable stress in areas of finances, employment, childrearing and marriage roles (Carlson, 1977; Star, 1978). Certainly these stressors, combined with fear of violent attacks, can result in high levels of tension,

justified feelings of persecution and a desire to avoid realilty. Many of these studies report over one-half of the women considered suicide at some point (Stark & Flitcraft, 1981). These studies also indicate that the majority of the women had tried to free themselves numerous times and in a variety of ways. Most of the women had reached out at some point to family, friends, police, courts, medical care system, and social service agencies. (Star 1978, Dobash & Dobash, 1977; Carlson, 1977; Labell, 1979; Flynn, 1977; Appleton, 1980).

Understanding Battered Women

Many authors and practitioners report that a primary obstacle to a battered woman's ability to extricate herself from her violent situation is the lack of support she feels from individuals and society at large. Societal myths are potent vehicles for keeping women isolated and locked into violent relationships. Many professional helpers base their responses to battered women on a variety of myths which blame the victim and excuse society for its major role in perpetuating violence against women. Myths appear to serve as rationalizations, protecting others from their own vulnerability. If the victim is to blame, then the same thing won't happen to me. In addition to victim blaming, myths operate to explain away the facts and excuse

society, and therefore all society's members, from their role in perpetuating this violence.

What is clearly true is that battered women are trapped in violent relationships for many years. They are physically damaged, humiliated, devalued, and psychologically manipulated and controlled. Why do women stay in these abusive relationships? What obstacles exist which hamper a woman's ability to empower herself to seek a safe existence?

All women are victims of a society which sharply defines appropriate gender role behavior. Women are encouraged to develop femine gender identification, learning behavior patterns such as passivity, fear of assertion, and fear of success. Women are also trapped by our traditional value system with its heavy emphasis on the sanctity of marriage and the home. Many women stay in abusive marriages because of religious or societal intolerance of divorce and single lifestyles for women. Women also justly perceive societal distaste for single parent families and children from "broken homes". Fear of making it alone as a single parent is a potent obstacle.

Female gender identification places heavy emphasis on nurturant behaviors. Women strive to maintain marriages and partnerships believing that if they try harder, nurture more, than their relationships will work out successfully. Love for the abuser, carried over from an

earlier period in the relationship may exist. Abusive men are not always beating their partners. Periods of days or nights might elapse between abusive episodes. Abusers may even appear remorseful. Many women cling to the hope that their mates will reform, change their behavior, and stop the abuse. She hopes that if she placates him, loves him more, than he will not beat her. This may reflect her person centered approach to life and her belief in the importance of relationships and family ties.

Change from marriage or partnership to a single life is often quite frightening for women with little or no experience living independently. An overwhelming number of women go from their parents to the home of their spouse or lover. Independent living is riddled with uncertainties. Maneuvering through the maze of obstacles presented in the employment, housing, and childcare sectors seem insurmountable. There are few role models for women, models of successful, independent women and mothers.

Many women tolerate years of abuse citing their unwillingness to deprive their children of their father, often accentuated by the children's requests to make peace and stay together. Many authors report that children are a prime factor in a woman's inability to leave (Bell, 1977; Carlson, 1977; Greaney, 1984; Martin, 1976).

The combination of limited income or earning potential, probable lack

of child support payments, fear of losing custody and concern for possible retaliation towards the children leave many abusive relationships intact.

Guilt and shame are reported by many battered women as significant obstacles to freeing themselves from their violent situations (Ball, 1977; Campbell,1984; Duggan, 1981, Greaney, 1884; Hendrix, 1978; Leiberknecht,1978; Martin, 1976; Schuyler, 1976). It is a woman's self esteem which is vulnerable when a marriage dissolves as society dictates that she is ultimately responsible for the home and family harmony. Shame and guilt are also experienced as a result of the beatings and victimizations. The more a woman feels and is treated like an object or possession to be beaten, the more guilt and shame she experiences for not being able to get out or stop the violence. It is not surprising that women often feel guilty and blame themselves, as social scientists, police, lawyers, social workers, clergy , doctors and nurses blame them as well.

After repeated victimizations a woman's sense of self worth may be seriously damaged. Her life may involve a constant state of fear; fear of the next and potentially more painful and life threatening attack; fear of more severe beatings and homicide. This fear is a potent immobilizer, leaving women unable to act even when a mechanism for escape is made available. Immobilization, defined as a paralyzing

sense of having no control over one's life, is cited by many authors as a key factor which traps battered women (Campbell, 1984; Duggan, 1981; Goldberg & Carey, 1982; Greaney, 1984, Hendrix, 1978; Hilberman, 1980; Parker, 1979; Star, 1978; Van Stolk, 1976; Walker, 1976).

A review of the research and literature in the area of abuse points to economic disenfranchisement as an important factor keeping women in battering relationships. All authors previously cited report economics as a primary reason for women maintaining abusive relationships. Many women, having no employment outside the home, have no personal income or access to their mates income. A surprising number of women have no access to bank accounts, hence no economic resources at their disposal. Women who are employed outside the home frequently contribute all their often meager earnings to the domestic budget or for child care, leaving little if any reserve for future flight. Women who are employed outside the home are keenly aware ot their limited earning potential. Few women are employed in professional positions, most women earn minimum wage or slightly above. Since 1980, five million women and children have sunk below the poverty level (Peer, 1984).

Carlson (1977) reported that most women in her sample were fearful of their inability to adequately support their children. Most of these women did not have the education or job skills to succeed financially. Fear of economic collapse and inevitability of living in poverty cannot be trivalized or underestimated. In a country where the courts are ineffective in assuring adequate child support and where 80% of all welfare recipients are female heads of household with children, it then becomes obvious why many battered women do not see independent living as a viable option.

When abused women do seek assistance, help is often denied or rendered ineffective. Many women who finally muster enough courage to leave abusive relationships or seek help discover all too often that they are victimized a second time by the institutions to whom they turn for help. The police, lawyers, and judges do not often view a women's assault by a male partner as a serious crime. Professionals in the health care system who often subscribe to sexist attitudes toward women often blame the victim. Lack of knowledge concerning the dynamics of woman abuse leave helpers riddled with myths which unwittingly contribute to a woman's sense of helplessness and despair. In addition education originating in the medical profession focuses on the treatment of immediate physical injuries with no attempt at helping the client cope with their life situation.

Enumerating the myriad of reasons battered women stay in abusive relationships enables professionals to see women and their life situations more clearly. Victimization, both on a personal and a sociopolitical level, traps women in their violent homes. Stereotypic, negative, sexist attitudes towards women are well ingrained in our society and serve to maintain a system of male patriarchy and privilege. Women endure abuse not out of enjoyment, but because society makes it extremely difficult for her to do anything about it. As Van Stolk aptly states, "The idea that if a woman really wanted to leave her husband, she could overcome the obstacles on her own, is a bureaucractic and social fantasy" (Van Stolk, 1976:12).

Unfortunately the battered woman is a study in victimization. She is first victimized by her assailant and then further victimized by a society which places heavy emphasis on the sanctity of the home and marriage. By a society which encourages female passivity and subservience and offers women limited educational and employment opportunities. A society which economically and politically disenfranchises women, which increases their dependence on marriage, even violent ones. A society which creates a male role as "head of household" with the attendant right to discipline and control. The patriarchial culture is not the cause of violence, rather it is the

context in which men behave violently to maintain political and economic superiority.

Counseling Battered Women

The feminist literature argues that effective helping strategies should seek to empower women to gain control over their own lives. Feminist counseling aims to help women differentiate between those difficulties which they are responsible for and those problems which are due to sex role stereotyping and male domination. This literature argues that women are not responsible for their own abuse. Helping strategies aimed at raising self esteem, increasing self confidence and promoting independence are cited as crucial. Support is an invaluable tool to combat the isolation, guilt and shame experienced by battered women.

Feminist counseling seeks to help battered women examine their situations from both a personal and an environmental perspective, to separate the internal from the external. A belief in this approach will ultimately provide a greater sense of personal power (Ball & Wyman, 1978). If battered women are provided the opportunity to explore their life situations, examine their feelings, and understand the historical and socio-cultural influences over their lives then personal

empowerment will occur. The development of an independent self, in or out of the relationship will be enhanced. Feminist counseling seeks to strengnthen female identity, to radicalize women, and ultimately to effect an equal balance of power within relationships.

Traditional helping and counseling approaches are criticized for their inability to facilitate the long range empowerment and improved self esteem critical for battered women. Traditional counseling is often based on stereotypic views of women and serves to entrap women in violent lives. Professionals are often skeptical towards battered women, disbelieving their complaints, suspicious of their possible provocation, and contemptuous of them for staying in abusive relationships (Klein, 1981).

Professionals who base their practice on traditional counseling models or who rely on linear-causal models of human behavior will inevitably incorporate many myths into their helping. The origin of the problem will always be seen as lying within the client. Helpers who have gone through traditional schooling are said to be guilty of secondary victimization of battered women (Roy,1977). It may be that they are taught to objectify their clients and to see problems as dispositional in the client, rather than situational, the result of social and political injustices.

Summary

So it can be seen that a variety of factors contribute to the incidence and prevalence of battering. Cultural and societal attitudes regarding the use of force and aggression operate to sanction violent behavior in men. Social learning serves to foster the transmission of male violence. The sexist structure of American society, with men maintaining power and control over women is a key factor. Economic and political exploitation are the tools of repression and domination. Societal attitudes which reinforce the myth of family harmony and family privacy clearly operate to keep battered women isolated and excuse social institutions from intervening.

Attribution Theory

Attribution theory postulates that people make assumptions about responsibility for problems and responsibility for their solutions. Although people may not be generally aware of the underlying assumptions they make, assumptions are made and have direct consequences for their own behavior and for the behavior of the people they influence. Research has shown that the inferences made by trained helpers about a client's need and about the nature of a client's

problem have marked impact on the nature of the help provided. A number of researchers (Bateson, 1975; Caplan & Nelson, 1973; Groffman, 1961; Halleck, 1971; Langer & Abelson, 1974; Rosenhan, 1973) suggest that there is a discreetly negative effect due to a systematic bias in the way trained helpers make inferences about client needs.

These researchers claim that trained helpers display a dispositional bias when inferring the nature of a client's needs and problems. According to this research trained helpers are likely to infer that a client's problem lies with the client as a person rather than with some aspect of the client's situation. This holds true not only for helpers trained in psychotherapy, but also for the behavior of clinicians, counselors, social workers and ministers trained in situation-oriented and interactive models. If trained helpers do exhibit a dispositional bias, viewing the nature of the problem as residing solely within the client, then it raises serious doubts about the appropriateness of most institutional helping services.

In order to understand the process by which trained helpers develop a dispositional bias one can review the literature in the field of attribution theory. Attribution Theory (Heider, 1958; Jones & Davis, 1965; Kelley, 1967) provides a conceptual framework for identifying and examining sources of inferential bias. These theorists postulate

that the most important attribution a helper makes about a client's problem is a locus attribution rather than causal attribution. The helper is more concerned with determining where the problem lies rather than what caused the problem. Locus attribution involves a dichotomous choice: dispositonal versus situational.

When confronting a given client problem the helpers most basic attribution is to determine whether the problem lies within the client (a dispositional attribution) or with the client's physical and social environment (a situational attribution).

Helping

Much of the existing literature on helping predominantely concentrates on the isssues of who helps and when and how much help they give, rarely focusing on the nature of the help that is offered. Yet current research has demonstrated that it is the kind of help that is offered that is a crucial determinent in the success of helping interventions. Not all well intentioned helping strategies actually achieve their desired goal of helping the client solve their problem.

The specific helping stategies chosen appear to be based upon the beliefs held by the helper concerning the nature of the client's problem and the appropriate solution. Brickman et al (1982) contends that the

helping interaction is justified and shaped by answers to two basic questions: (1) Who is to blame for the problem, that is, who is responsible for the cause or origin of the problem, and (2) Who is to have control over the problem, that is, who or what is responsible for the solution to the problem. The judgements made concerning the client's problem are based on a set of assumptions and expectations about the client, the helper, and more fundamentally, on human nature itself. These judgements directly influence the meaning and purpose of selected interventions and often imply a unique helping strategy. (Karuza, Zevon, Rabinowitz, & Brickman, 1982). These researchers posit that both the client and the helper possess a set of assumptions about the nature of the problem and what actions should be taken to solve it. These assumptions will guide the approach taken by the helper and influence the activites of problem identification and diagnosis, development of treatment plan, and the setting of therapeutic goals.

Given that the explicit rationale of any helping intervention is to solve the client's problem, then a situation in which both the client and the helper subscribe to a similar set of assumptions concerning the problem and solution might prove beneficial. Yet helpers interventions may have implicit functions that are quite different, such as caring or social control (Kaswan, 1981) Any helping orientation may contain both explicit and implicit aspects and attempts to socialize clients

into accepting views about their problems, potentials, and possible solutions (Rodin & Janis, 1979). Postulating from this perspective it can been seen that clients might disagree with helpers concerning the nature of the problem and what form of help will be appropriate. It is the task of the helper to implement a successful intervention and therefore they must recognize that their professional diagnosis of the problem and its solution may, or may not, coincide with the assumptions held by the client (Karuza et al, 1982).

Attribution Theory and Models of Helping

Brickman, Coates, Rabinowitz, Karuza, Cohn, and Kidder (1982) have developed a framework for examining the concept of helping based on the tenents of attribution theory. They define helping as:

> an act or relationship that facilitates the progress of its target toward that target's goals, typically by solving problems, though perhaps by redefining the actor's goals in a way that reduces the impact of these problems.

The Brickman et al (1982) Models of Helping state that each helping situation involves two separate issues - blame and control. Both helpers and the recipients of help want to know who should be blamed for the problem and who should be expected to solve it. In theory the

client can be perceived as having either high or low responsibility for the cause of the problem, and be expected to have high or low responsibility for the solution to this problem.

By crossing these two attributional dimensions Brickman et al (1982) devised four possible models of helping. These models were designed to provide a framework for assisting clients to achieve desired goals and are clearly based on differentiating responsibility for the origin of the problem from responsibility for the solution to that problem. The model chosen for use with a client will depend on the frame of reference held by the helper and will result in a specific helping orientation. The four helping models are described in the following section.

Moral Model

The moral model is the model which attributes responsibility for both creating and solving problems to the individual. The individuals problem is their own making and they are morally obligated to help themselves. The individual is seen as basically lazy or stubborn, someone who has created their own problems, or at least someone who has not exerted the necessary effort to solve their problems. Since the problem is entirely the making of the individual then the solution must be generated by this same individual.

In the moral model others are not obligated to help, nor capable of helping. Each individuals problems are their own making and each person must find their own solutions. If help is given, help usually comes from peers who lecture the individual to change and improve. Despite the fact that the client is seen as inherently lazy and misdirected, they are also seen as basically strong and capable of solving their own problems. They need only to focus their energies and strive for permanent change.

People who have subscribed to the Erhard Seminar Training (EST) and the rational-emotive therapies are strong supporters of the Moral Model of Helping in that they urge clients to see themselves as active causal agents who are responsible for creating and solving their problems (Brewer, 1975). Mutual self-help groups may also be examined under this model as in these

groups individuals are reminded that they are solely responsible for their fate and are encouraged in their efforts to help themselves. (Hill & Stone, 1975).

The activity of the professional helper under the moral model consists only of strategies which force the client to take responsibility for their problem and its solution. The type of help offered under the moral model may be useful for individuals who are particularly resourceful as it compels people to take action on their own behalf.

People are encouraged to take responsibility for finding solutions to their problems and for changing their environment. The primary advantage of this model is that it encourages the client to assume total responsibility for their lives and motivates them to work harder and more effectively in solving their own problems (Brickman, Linsenmeir, &McCareins, 1976; Janoff-Bulman & Brickman, 1982). If success in problem solving occurs then this model can result in feelings of competencey and confidence. It can minimize client dependency and passivity.

However it may also lead people to a blind conviction that the world is truely just (Lerner & Miller, 1978) and that what happens to us in life is always justly deserved, that somehow victims deserve their fate. Clients may also adopt a world view in which they see everything as contingent on their own behavior and therefore the solutions to all problems rest solely in their own stregnth of will. This can certainly lead to feelings of loneliness as well as an unrealistic notion of self-sufficiency, even if the client's problems are truely beyond their control. A more serious consequence is that it can lead to the belief that all things are possible. Further, the avoidance of professional help and the over reliance on peers to help one find solutions to their problems is not always effective. People are often reticent in seeking help from friends. In addition clients might not seek help readily as

under this helping model the need for help might be considered a sign of inadequacy or incompetence.

Compensatory Model

The compensatory helping model states that individuals are not responsible for their problems but are responsible for finding their solutions. In this model people are viewed as having to personally compensate for obstacles imposed on them by their environment. The problems which individuals face arise from the failure of the social environment to provide the necessary resources, experiences, or services which are crucial for effective functioning in the world. The individual must therefore compensate for these deficiets. Although the cause of the client's problem is seen as beyond their control, the solution is clearly seen as within their grasp. This model of helping springs from an optimistic view of the client and rests on the assumption that human nature is inherently good. It also assumes that given the opportunity all individuals can find their adaptive fit in the environment.

The client is encouraged in their problem-solving and urged to find solutions to their own problems. It is believed that clients can successfully solve their own problems by learning new skills and by becoming assertive in their attempts at forcing others to yield

resources, training, and opportunities. It is the responsibility of the individual to determine what actions will be helpful and to evaluate the success or failure of the help they receive. In the compensatory model the client is the essential agent of change. However the individual must seek help from peers, subordinates or professional helpers in order to solve their problems which arise form the social environment.

The professional helper clearly assumes a subordinate role by adopting a cooperative relationship with the client. Professional helpers are viewed as people who can offer the necessary help to compensate for the lack of resources and opportunities experienced by the individual. It is their role to help the client mobilize resources. This is done through training and actions aimed at creating needed opportunities for the client. The Comprehensive Employment and Training Act (CETA) program, Project Head Start, and many of the grass roots organizations providing services to abused and raped women are examples of helping based on the compensatory model.

The compensatory model is ideally suited for clients who are seeking access to the knowledge and services of health care providers with the purpose of preparing themselves to solve their own problems. This model encourages people to solve their own problems without implying responsibility for the problem. While acknowledging that the origin of an individual's problem lies within the social environment this model

does not victimize the victim. Rather it seeks to empower the client to take control over their destinies and seek the help needed to secure environmental changes. This model fosters self-respect and gives clients credit for developing solutions for their problems. Stategies employed by the helper focus on assisting the client to identify the nature and scope of the problem, examine solutions, and assist the client to secure the resources necessary for problem resolution. A possible drawback to this model is that individuals may become bitter if they feel continually faced with solving problems which they did not create (Karuza, Zevon, & Rabinowitz, 1980).

The moral and the compensatory model both assume that people are responsible for solving their own problems. After reviewing the literature on attribution, achievement, and helplessness, Brickman et al (1982), postulated that people who believe that they can control their own outcomes are more likely to persist in problem solving and display fewer effects of stress. They hypothesized that holding people responsible for creating solutions for their problems increased competence (Brickman et al., 1982). Conversely, not holding people responsible for finding the solutions to their problems would increase dependency. Reseach has been conducted to support this hypothesis (Karuza et al., 1982; Cronenwett, 1980).

Medical Model

The medical model assumes that individuals are neither responsible for their own problems nor for their solutions. The practice of modern medicine most clearly examplifies this attributional assumption. People are seen as biological/psychological systems who become injured and malfunction. This injury, malfunction or sickness is not the responsibility of the individual. Likewise the individual is not responsible for the solution, for generating wellness. The individual is expected to get well by seeking and utilizing the help of expert practitioners. Implicit in this model is a view of the client and of human nature as basically passive. Individuals are encouraged to adopt the sick-role and by doing so they are exempted from ordinary social obligations. However they must try and get well by seeking and utilizing the help of experts.

The professional helper is seen as the primary agent of change. These experts are skilled at problem identification and competent in prescribing solutions. The client must only adhere to the prescribed solution and await the helpers evaluation of the successfulness of the solution.

The obvious advantage of the medical model of helping is that it allows people to seek and accept help without assuming responsibililty for the creation of the problem. The individual is not blamed for their

condition. This is particularly valued by people with conditions which might otherwise be punished under another model, such as obesity and alcoholism, but are approached with treatment under the medical model. A clear danger to this model is that it fosters dependency (Langer and Benevento, 1978). Clients in the medical model of helping do not believe they are capable of solving their own problems nor do they feel capable of evaluating the effectiveness of the help they receive. This attitude results in passivity and the inability to protest undesirable interventions or advocate for oneself. Clients may be dissuaded from questioning the diagnosis or treatment (Rodin & Janis, 1979) and may lead to a situation of learned helplessness which results from lack of freedom and self-determination (Rodin & Langer, 1977).

Enlightenment Model

This final model of helping attributes the individual with causing their own problems yet does not believe that they are responsible for their solutions. People are blamed for their problems and are seen as guilty or sinful. The past behavior of the individual is the direct cause of the current problem. Because attribution of responsibility leaves most individuals with a negative self image the enlighentment model relies on the use of enlightenment or socializing to foster personal acceptance for problems. Implicit in this model is the belief

that clients are out of control and unable to manage their lives. The individual must become enlightened as to the extent and seriousness of the problem they have caused and is encouraged to submit to the helper. Self-destructive impulses are controlled only if the individual submits to the authority figure, the helper.

It is the role of the helper to help the individual accept the difficult changes necessary to solve their problem. It is important to note that since the solutions to the problem lie outside of the individual then a relationship with an external authority figure must be maintained in order for successful problem resolution. It is only through aknowledgement of guilt and submission to authority that the individual can be expected to solve their impulse problems. Groups such as Alcoholics Anonymous and Overeaters Anonymous adhere to the tenents of the enlightenment model with past recipients of help preaching others to follow the same dictates as they have done.

The enlightment model can be particularly useful for individuals who are unable to control behavior they consider problematic or undesirable. Acknowledging one's inability to control one's problems may provide a sense of relief. Additionally the reliance on professional helpers and a therapeutic community may provide the support and structure needed to engender in clients the belief that it is possible to control their problems (Karuza et al, 1982). The primary disadvantage of this model

is that the individual is encouraged to place great power in the hands of the helper. The client often feels they have no control over their lives with the belief that the helper possesses the power to solve their problems. This may lead the client to overidentification with authority figures and a course of action in which the client restructures their entire life around the source of authority (Cummings, 1979). Both the medical and the enlightenment model attribute responsibilty to the helper for identifying the solutions to a clients problems. This certainly straddles the helper with the responsibility for determining the types and the success or failure of helpful interventions.

Nursing and Helping

The practice of nursing has always involved the act of helping clients. Almost every definition of nursing includes the words "help" or "assist". Yet many of the conceptual models which have been developed to explain and predict nursing phenomena have not explored the concept of helping (Johnson,1980; King,1971; Neuman, 1982; Orem,1971; Roy,1981; Rogers,1971). These models invariably include the concepts of man, health, nursing and environment but stop short of acknowledgeing helping as a key concept.

Assumptions have been made in most nursing theories about the practice of helping but these assumptions have not been critically examined (Cronenwett, 1982). Yet the process of helping is a critical component of the practice of professional nursing. The first step in providing effective and helpful intervention to clients is to determine the specfic nature of the problem. The nursing profession describes this as the assessment phase of the nursing process. It is during this step that data are gathered, analyzed, and problems are identified. The nurse arrives at an answer to the question: "What seems to be the problem" and completes the assessment phase by outlining specific nursing diagnoses. The answer to this question and the resultant nursing diagnoses, whether well founded or not, will have significant impact on the helping process and the well being of the client. Certainly an examination of the ways in which nurses help could not only improve the effectiveness of nursing interventions but also aid future theory development and reseach in nursing.

Despite the fact that the nursing literature has not reflected a clear inclusion of the concept of helping, the definitions and models of nursing that have been advanced during the past two decades have contained implicit and explicit statements concerning attribution of responsibility for problem and solution. Cronenwitt (1982) categorized concepts and definitions of nursing found in the nursing literature

according to the Brickman Models of Helping (Brickman et al., 1982). She found that over half of the nursing models and definitions reviewed contained statements that implied that nurses use a medical model orientation to helping. Nowhere in the nursing literature did it imply that clients were responsible for their health problems. Rather clients are seen as sick and not responsible for their problems.

The only other model of helping advocated in the nursing literature is the compensatory model (Orlando, 1961; Hall, 1963; Kinlein, 1977). Hall (1963), the founder of the Loeb Center for Nursing and Rehabilitation in New York expressed this orientation clearly:

> What nurses at Loeb strive for and achieve most of the time is to help the patient determine what his goal is, perhaps help him bring it into clearer perspective, and then, with him, to work out ways to get there, at the patient's pace, consistent with his medical treatment plan, and congruent with the patient's sense of who he is. [Bowar-Ferres, 1975, p.813]

In this definition of nursing the patient defines both the problem and the solutions necessary to achieve a higher level of wellness. The role of the nurse is to assist the clients in their endeavors to clarify and reach their own goals.

Cronenwett's (1983) review of the nursing literature did reveal many models which fell on a continuim between the compensatory and the medical model. In these models both the nurse and the client were

considered responsible for defining the problem and its solution (King, 1981; Wiedenbach, 1969; Peplau, 1952). The nursing process which is the primary framework for nurse-client problem solving requires that nurses work with clients to identify nursing diagnoses and plan therapeutic interventions. Cronenwett (1983) points out that the crucial point is who makes the decision and who is ultimately responsible for the outcome. She argues that the terminology implied in the nursing process literature conveys the notion that the responsibility belongs to the nurse.

Variables which influence Helping

Despite the preponderance of nursing models which do not blame clients for their own problems, individuals are often labeled as "problem patients". Research has demonstrated that in reality clients are often blamed for their problems, particularly patients with self-destructive life-styles or those who chronically complain (DeJong, 1980; Lorber, 1975). Researchers have also found that professional helpers are more likely than either the client or nonprofessional helpers to see the locus of the problem in the client rather than in the situation (Batson, 1975; Wills, 1978). The actual training of professional helpers may predispose one to attributional statements and subsequent

choice of helping model. Training often results in clinical expertise in a very narrow range with helpers relying on familiar and learned strategies in their practice with clients. Snyder (1977) found evidence suggesting that behaviorally trained therapists were more likely to view problems as situationally caused, whereas psychodynamically trained therapists were more likely to view the problem as personally caused.

The personal experience of the helper may also influence the helping process. Wills (1978) reported that helpers show a tendency to make personalistic attributions about clients, often attending to the negative aspects of the client's behavior. It has been postulated that some helpers actually "burnout" as a result of repeated failure of interventions with certain clients (Maslach, 1978). This may lead the helper to adopt a moral model in working with certain clients, blaming them for their problems rather than helping them (Lerner & Miller, 1978).

One factor that is likely to influence the choice of helping model is the beliefs, attitudes and stereotypes held by the helper concerning the client population. It has been demonstrated that age stereotypes can affect the preference for, and choice of, helping models, with the medical model predominanetly chosen for use with elderly clients even though their problems were no more serious or debilitating than those

of younger adults (Karuza & Firestone, 1979). The biases held by the helper not only affects the choice of helping model but also influences the design and implementation of interventions. If these stereotypes are inaccurate they may result in ineffective treatment, or more seriously, socialize the client into accepting potentially dysfunctional views of themselves and their problems (Karuza et al,1982). Clients who refuse to accept the orientation of the helper may be labeled as problematic, difficult, or noncompliant. Ultimately the helper may choose to avoid the client, leading to the creation of new problems and setting the stage for iatrogenic disorders (Taylor, 1979). Research has also outlined a process of "secondary victimization" of the client in which clients who were pushed to use the medical model orientation were unable to take responsibility over their own lives when friends and professionals were finally ready to stop helping (Coates & Wortman, 1980; Janoff-Bulman, 1979; Brickman et al., 1982). Clients may then permanently embrace the medical model orientation.

Given the effect of attributions about responsibility on the helping process, many clinicians argue that the most successful helping strategies should originate from a definite matching of the helping model preferred by helper and client. Others contend that the helper should select a helping model which seeks to empower the client towards problem resolution. In this instance the helper chooses a

specfic model based upon an appraisal of the problem's etiology, the client's potential, and the desired effects of the helping model itself. Helpers therefore choose a model with the purpose of attempting to change the client's attributional assumptions, with this serving as one of the goals of intervention (Ross et al, 1969). This strategy is based on the premise that clients often accept the interpretations of helpers (i.e., the "Barnum effect; see Snyder et al., 1977) and that helpers can actually redirect the client's view of themselves and their problems , reducing feelings of guilt, dependency, hopelessness, and anger in the client (Karuza et al., 1982).

In this vein the literature in the field of woman abuse argues against attributing responsibility for the problem onto the woman, the victim, as this serves only to reinforce guilt and immobilize the client. Instead the literature points to the use of a Compensatory Model where the client is not seen as responsible for their own abuse, but they are responsible for seeking solutions to their problem. It is believed that this approach is the most successful in assisting abused women to solve their own problems and empower their personal lives. The Women's Movement and the tenents of Feminist Therapy argue for strategies which do not blame women for their victimization. Helping approaches which seek to foster self-esteem, encourage problem-solving, mobilize resources, and empower women form the basis of feminist helping.

CHAPTER 3

METHOD

Introduction

The purpose of this chapter is to describe the methods and procedures used to collect and analyze the data of the study. For the purpose of presentation, this chapter has been divided into four sections; the design, the subjects and sample, the instruments, procedure used in conducting the study and methods in analysis of data.

Design

This research study examined the helping orientation of a sample of one hundred and sixteen (116) registered nurses towards battered women. Nurses' preference for choice of helping model employed with battered women was investigated. The relationship between specific education and clinical experience in the area of battering (the independent variables) and one's preference for helping model (the dependent variable) were examined. Finally, factors which relate to

nurses preference for a model of helping in their practice with battered women was examined. The independent variables were measured by responses on the Educational/Experience Questionnaire (EEQ) (See Appendix A) and the dependent variable was measured by means of responses on the Help Orientation Test (HOT) (See Appendix B).

Subjects and Sample

Data were obtained from two groups of registered nurses using a non-random sampling technique, which therefore may limit the generalizability of this study. Emergency Department Nurses constituted the first group and were chosen for this sample because of their frequent contact with battered women. The second group was composed of nurses who had attended a 3 day National Nursing Conference on Violence Against Women. This Conference Attendee Nurse group was selected because they represented a sample with some knowledge on the topic of battering. Through this sampling method, two groups of nurses were represented in the sample: one group of clinicians who incidentally see battered women in their practice; the second group were nurses who are knowledgeable about battered women but may not have practiced with battered women. The investigator wished to get an approximately

equal sample of 50 subjects. All subjects were registered nurses who were currently employed in the profession of nursing.

Responses from the first group were obtained by a non-random sampling of emergency department nurses in Western Massachusetts. The nurse managers of the emergency departments of three hospitals assisted in obtaining the sample. One hospital served a primarily rural population, one a mixed urban/rural population, and one a predominently urban population. The three nurse managers were contacted by the investigator by telephone and asked to facilitate the obtaining of a sample of emergency department nurses. This initial contact was followed by a letter confirming the arrangements for distribution and collection of the instrument. (See appendix C)

The second group of nurses consisted of a convenience sample of nurses who attended the First National Nursing Conference on Violence Against Women held November 1-3, 1985. This mailing list was obtained from the Nursing Network on Violence Against Women, the sponsors of this national nursing conference. This sample included nurses from a variety of practice settings located in various geopraphic locations throughout the United States.

The instruments were mailed to the entire mailing list of 125 nurses who had registered for the First National Nursing Conference on Violence Against Women. A letter was included in the mailing asking for

assistance in this research project. Instructions included in the package to both groups informed the subjects to complete the instrument and return it in a self-addressed stamped envelope. The target number of participants in this study was set at 100: 50 from each group. At the end of four weeks 116 responses had been received, eliminating the need to do a second mailing.

Instrumentation

Help Orientation Test (HOT)

The Help Orientation Test (HOT) is a 40 item instrument with each item completing the stimulus, "People receiving help. . . " . This tool was constructed by Rabinowitz (1978) to reflect the four models of helping defined by Brickman et al (See Chapter 2). Ten themes were developed which correspond to ten categories of orientation to help reflected in each of the four models. Four alternative responses to each theme were developed with each alternative response reflecting a particular characteristic of the category corresponding to one of the four models. Thus the questionnaire consists of ten items with four alternatives for each item. The four alternatives were randomly arranged in each of the ten sets. The ten characteristics and their model alternatives are displayed in table 2.

Table 2

Model Themes

Theme	Alternatives	Model
1. Kind of help needed	Only to be shown	Moral
	To see that they are not alone	Enlight
	Fair chance	Comp
	Therapy	Medical
2. Characteristics of recipients	Stubborn	Moral
	Unaware	Enlight
	Deprived	Comp
	Ill	Medical
3. Sources of help	Time to think	Moral
	Friend	Enlight
	Tutor	Comp
	Doctor	Medical
4. Result if no help	Ok even if no help	Moral
	Self destructive	Enlight
	Hostile or violent	Comp
	More ill	Medical

(Continued on next page.)

(Table 2, continued)

5. Extent of help needed	Get themselves together	Moral
	Long relationship with other with similar experience	Enlight
	Fixed temporary period	Comp
	Until cured	Medical
6. Critical component of help	Complete self reliance	Moral
	Guidance from people with experience in the same trouble	Enlight
	Given deserved resources	Comp
	Skillful help	Medic
7. Perception of donors	Enjoy giving advice	Moral
	Discovering new brother or sister	Enlight
	Seeing justice done	Comp
	Doing highly respected	Medical
8. Kind of help needed (similar to #1)	Reorientation	Moral
	Dedicate to higher cause	Enlight
	Resources of more fortunate	Comp
	Experienced trained care	Medical

(Continued on next page.)

(Table 2, continued)

9. Alternatives to help (similar to #1)	Discovery of inner self	Moral
	Illusion of doing all for self	Enlight
	Unapproved means	Comp
	Withdraw and fall apart	Medical
10. Circumstances of help again	Reminder of self responsibility	Moral
	Matter of community	Enlight
	Further unfairness	Comp
	Fall ill	Medical

This instrument utilized a seven point rating scale with zero and six at the poles. Zero means not at all true; six means completely true. In all cases high ratings indicated high endorsement of the model alternative. (See Appendix B). The instrument was employed to determine which model of helping is most consistently preferred by nurse respondents when intervening with battered women and to correlate helping preference with educational and clinical experience.

Reliability & Validity of the HOT

Following completion of the survey reliability estimates were obtained using Cronbach's alpha (Cronbach, 1951). Cronbach has defined coefficient alpha as the mean of all possible split-half coefficients, based on items all presumably measuring the same attribute, or as a measure of equivalence of random samples of like items in a test. Cronbach's alpha was used to measure internal consistency among the 10 items in each model scale. The researcher hoped for a reliablity coefficient of .70. Items were dropped from the analysis until alpha approached as close as possible to .70.

Rabinowitz (1983) tested these scales on a sample of 190 college students, using Cronbach's coefficient alpha, and found the reliability of each of the scales as follows: moral model items, alpha = .6705; enlightment model items, alpha = .5800; compensatory model items, alpha = .6764; and medical model items, alpha = .7400. In a previous use of this instrument with smaller samples of registered nurses reliability estimates were the following: moral model items, alpha = .5389; enlightment model items, alpha = .7104; compensatory model items, alpha = .7098; medical model items, alpha = .7456 (Ryan, 1986).

Construct validity refers to the degree to which an instrument measures the theoretical construct or trait that it is designed to

measure. It can be assessed in several ways but it can never be definitely established (Wilson, 1985). Validity is difficult to achieve. However the previous uses of this instrument by Rabinowitz (1978) and Ryan (1985), in which different methods were used to measure the same trait, were useful in establishing convergent validity of the four models.

The Education / Experience Questionnaire (EEQ)

The subjects were also asked to complete a questionnaire, designed by the investigator, called the Educational/Experience questionnaire (EEQ). This is a 31 item questionnaire designed to examine the educational and clinical experience of nurses related to battering and designed to assess their attributions about battering . The first eight items asked respondents to indicate their age, sex, ethnic group, marital status, and level and type of educational attainment. Items 9-13 elicited information about the amount and type of clinical experience in nursing.

Questions 14-17 asked respondents about the amount and type of any specific education they have obtained on the topic of battering. Questions 18-23 probed respondents about personal and clinical experience with battered women. Questions 24-26 employed a seven

point scale designed to probe respondents perceptions of the adequacy of their knowledge and skills in the area of battered women. These were followed by Question 27, an open ended question calling for a description of any knowledge or skills the respondents felt that they were lacking in relation to helping battered women.

Finally items 28-29 employed a seven point scale to assess the attributional assumptions made by the respondents regarding battered women. A high score on the cause attribution scale or the solution attribution scale indicated that the nurses blamed the client for causing the problem or held her responsible for solving it. This is followed by items 30-31 which asked respondents to rate their feelings about battered women and their satisfaction with their practice with this population. (See Appendix A). Content clarity was established by piloting the EEQ with ten nurse experts.

Informed Consent and Instructions

The researcher included in the survey packet a consent letter which explained the purpose of the study and assured the subjects of anonymity and confidentiality. (see Appendix D). The cooperation of participants was acknowledged and all respondents were invited to obtain copies of the summary of the research findings.

One page of information and instructions accompanied the survey packet. It briefly introduced the study as one concerned with the nature of help and the people receiving help. The terms Battered Women and Helping were defined. The problem of generalizing across people and experiences was acknowledged, but respondents were still asked to make these generalizations and to answer all questions (See Appendix E).

Hypothesis Testing

Hypothesis One

In helping battered women, Emergency Department Nurses will prefer an enlightment model of helping more than any other model.

Means were obtained for each subject in the two groups of nurses on the four scales of the HOT. Individual preference for model was determined by the highest mean score on the four scales of the HOT. Cross tabulations between practice setting of nurses and highest means were determinied so that one could discriminate between preference for model of Emergency Emergency Department nurses and preference for model of the Conference Attendee Nurses.

Hypothesis Two

In helping battered women, nurses who perceive their clinical knowledge level as high on the topic of battered women will prefer a compensatory model of helping more than any other model.

After determining model preference, the perceived level of clinical knowledge of the nurses in this sample was measured by a scale item 0-6, (with 6 being high, 0 being low) on question 25 of the EEQ (See Appendix A). Responses on this scale was divided into high, neutral and low. A chi square test was performed to test for association between model preferance and perception of clinical knowledge level.

Hypothesis Three

In helping battered women, nurses who perceive themselves as well prepared in their practice with battered women will prefer a compensatory model of helping more than any other model.

After determining model preference, the perceived preparation of the nurses in this sample was measured by a scale item 0-6, (with 6 being high, 0 being low) on questions 24 and 26 of the EEQ (See Appendix A). Responses on this scale was divided into high, neutral and low.

A chi square test was performed to test for association between model preference and perception of clinical preperation.

Other Analyses

Information from the demographic section of the questionnaire was used to describe the sample. Information from the open ended questions were summarized and then categorized in meaningful groupings which were created by the researcher. A frequency and summary statement was made for each category using the research questions as a guide for categorizing data. The statements and the categories were then given to a jury of three nurse colleagues. Percentage of agreement between the investigator and the jury was calculated. Adjustments in the categories were made until 90% agreement was reached. Once data was obtained other appropriate analyses were performed.

CHAPTER 4

FINDINGS

Introduction

This chapter presents the descriptive data of the study and tests the specific hypotheses of the study. One hundred and sixteen registered nurses comprised the total sample of practicing nurses employed in this study. Two groups of nurses were chosen for inclusion in this sample. The first group consisted of a convenience sample of 57 Emergency Department Nurses (EDN) who were employed in the emergency departments of three hospitals in Western Massachusetts. The second group consisted of a convenience sample of 59 Conference Attendee Nurses (CAN) who had attended a three day National Nursing Conference on Violence Against Women, held at the University of Massachustts in November, 1985. The nurses in this sample were located in geographic locations across the United States. Categories of practice did not overlap, no nurse from the conference sample was an emergency

department nurse and no nurse from the emergency department sample had attended the National Nursing Conference.

Description of the sample

Of the 116 respondents, 109 (94%) were women and 7 (6%) were men. The mean age for both sexes was 39 years with a range from 24 to 59. The majority, 96%, were White; 1.7% Black; 0.9% Hispanic; and 0.9% Asian. Sixty-nine (60%) of the sample were married, 27 (23%) were single, 15 (13%) were divorced and 2 (2%) were separated. No one reported being widowed.

Nursing Education

The majority of the subjects received their basic education in a diploma program (46 or 40%). This is not a deviation from national statistics in which diploma education was the entry level for nurses in this age bracket. Twenty-seven nurses (23%) received their basic education in an Associate Degree program and 37 nurses (32%) received their basic education at the baccalaureate level. This is a higher than expected number of nurses prepared at the baccalaureate level as nationally only 25% nurses hold baccalaureate degrees.

While the subjects have been graduated from their basic program as long ago as 1948 and as recently as 1986, 30% of the sample was graduated at least 10 years ago and fifty percent have graduated since 1973.

Thirty-four percent (34%) or 39 subjects currently hold no degree or less than a baccalaureate degree. Thirty five nurses (30%) have a baccalaureate degree in nursing or another field as their highest degree. Twenty-five subjects or 22% have a Master in Nursing as their highest degree with 3 other (3%) reporting a Masters degree in another field. Fourteen nurses or twelve percent (12%) have a doctoral degree in either Nursing or another field.

Practice

Of interest to the study is not actual number of years since graduation but the number of years of experience in nursing. The subjects were asked to respond in 5 year categories, such as1-5 years, 6-10 years. The greatest proportion, 29% or 34 people, have been in practice for more than 20 years. Only 12%, or14 people, have been in practice for less than 5 years, with only 2 people reporting less than one year of practice. The mean years in practice was 11-15 years. This

sample clearly represents nurses with a considerable amount of experience in nursing.

Because of the selection process, the greatest number, 57 or 49% of the sample, were currently practicing in the emergency department. The rest, 24 or 21%, were employed in schools of nursing. This can be explained by the fact that the other half of the sample was obtained at a conference setting, which is often attended by nurse educators. The remainder of the sample were employed in other common settings for nurses such as hospitals, HMO's, psychiatric settings and home health agencies.

Sixty-seven nurses (58%) have been in their current practice setting five years or less and this length of time was also the mean. Thirty-one or 27% have been in the present practice setting for 6-10 years. Only 15% (17) have been in the current practice setting for greater than 10 years.

Education on Battering

When asked about whether information about battering was included in their basic nursing education program, only 20% or 23 subjects reported any information. Those who did report information in this program had less than 8 hours of content, with the majority reporting 2

class hours or less in their basic curriculum. Twenty-seven or 23% of the sample reported information on battering in a later educational degree program, primarily in a master's degree program in nursing. This ranged from 1 hour to 20 hours, with two thirds reporting more than 2 class hours of content.

In response to questions soliciting information about where subjects have received any information on battering, 97 or 84% stated that they received some information from newspaper or magazine articles, 95 or 82% reported reading books or journal articles, 89 or 77% viewed films or television shows on battering. Sixty-nine or 60% stated that they had attended a specific workshop or conference and 44 or 38% reported having attended a one to three hour session on battering.

When asked where the source of the most useable information about battered women was obtained, subjects reported a variety of providers of useable information. Journal and magazine articles were cited most frequently followed by work experience and experience with battered women. This was followed by information obtained via books, television and movies. Many subjects reported that the First National Nursing Conference on Violence Against Women provided them with the most useable information. A few nurses stated that they received the most useable information from doing original research or writing on this topic. Occasionally attendance at conferences or workshops was cited as

a source of useable information. A few subjects reported that experience they have had with battered women's sevice agencies provided them with the most information.

What is to be concluded from these answers is that professional journals or workshops are not cited as providing the most useable information. Indeed the lay and popular media appears to be the primary source of information on the topic of battering.

Contact with Battered Women

A variety of questions were asked to elicit information concerning clinical and personal experience with battered women. Since having a close friend or family member who has experienced battering might influence the thinking of nurse respondents, questions were asked to elicit this information. Information was also sought on the subject's own experience with battering as this might also influence nurse responses.

Ninety percent (104) of the subjects reported contact with battered women; only 12 or 10% of the subjects had never come in contact with women who are battered. Twenty-eight nurses or 24% reported not intervening with battered women. When asked to estimate the frequency of contact with battered women, 76 or 65% were unable to give a

monthly estimate but 27 or 23% encountered between one and five battered women per month. When asked how many battered women per year they encountered, 34 nurses did not respond; 11 reported seeing none; and 48 reported seeing between one and 12 women per year. Of interest is that 6 subjects reported seeing 30 or more battered women a year and 2 subjects saw over 60 women a year. It is presumed that these latter were nurses involved in shelter work with battered women

When asked if they had personally known any battered women, 47 or 41% reported knowing a co-worker and 61 or 53% reported knowing friends who were battered. Nineteen subjects (16%) stated that they had a relative who was battered; 3 people reported daughters who were battered; 12 reported sisters who were battered, and 9 subjects reported that their mother was battered.

Twenty-one people or18% stated that they themselves had been involved or are currently involved in an abusive relationship. Two subjects reported an abusive relationship lasting over 35 years; 8 subjects reported that the battering relationship lasted 5- 30 years; and 11 reported an abusive relationship lasting 3 years or less.

The information obtained documents that the nurses in this sample has significant contact with battered women in both the clinical and personal setting. The data on personal experience with battering lends

support to the reality that violence against women accurs in all ethnic and socio-economic categories.

Reliability of the Help Orientation Test

Cronbach's alpha, a measure of internal consistency among the ten items in each of the four scales in the instrument, (the Help Orientation Test - HOT) was selected as the estimate of the scale's reliability when used with this sample. It was hoped that a reliabiltiy of .70 for each scale would be obtained in order to be considered acceptable for this study. Items which were negatively or only slightly correlated with other items in the scale and therefore did not contribute to the reliability coefficient were deleted.

An alpha of .57 was obtained for the moral scale; an alpha of .63 for the enlightenment scale; an alpha of .55 for the compensatory scale; and an alpha of .75 for the medical scale of the HOT. Even with items deleted, the alpha for all except the medical scale would not go above .63. Deleting more items would not have increased the scales estimates of reliability.

The items deleted to achieve these estimates of reliability were as follows: moral scale, no items deleted; enlightenment scale, item #1 deleted ("Need to see that they are not alone"); compensatory scale,

items #2 and #5 deleted (" Need the fair chance they have so far been denied" and "Are deprived", respectively); and medical scale, no items deleted.

Tests of Hypotheses

Initial inspection of the data revealed that all nurses in the sample consistently chose the medical model in preference to any other model. Therefore the following analyses for test of the hypotheses was performed.

Hypothesis One

In helping battered women, Emergency Department Nurses will prefer an enlightment model of helping more than any other model.

Hypothesis One is not supported by the findings of this study. Emergency Department Nurses did not prefer the enlightenment model more than any other model. In fact they, like the Conference Attendee Nurses, preferred the medical model to any other model. Of the 53 Emergency Department Nurses for whom a model choice was evident, 39 or 74% chose the medical model; followed by the moral model, 9 or 17%; enlightenment model, 4 or 7%; and the compensatory model, 1 or 2%. For four of the 57 subjects a model was not able to be selected due to equal

means. Not only was the selection in this order but the mean scores for the scale items were in the same order: medical 33.28; moral 27.78; enlightenment 27.37; and compensatory 22.97.

Emergency Department Nurses and Conference Attendee Nurses did not differ in their primary choice of helping model since they both selected medical models. In the entire sample, 61 subjects or 56%, chose the medical model; 26 subjects or 24% chose the moral model; 16 or 15% chose the enlightenment model; and only 5 or 5% chose the compensatory model. In the total sample, eight subjects were unable to be categorized in any one model.

However the two samples did differ significantly in distribution of model choices. As can be seen in Table 3, the Emergency Department Nurses chose the medical model to a statistically greater extent than the Conference Attendee Nurses. It was also found that the two groups differed on their total choices of helping model, with the Conference Attendee sample choosing the compensatory model to a much greater extent than the Emergency Department Nurses.

Table 3
Chi Square of nurse subjects by model scores on HQT

Scale Scores	Nurse Subjects EDN	CAN	Total
Moral	9(17%)	17(31%)	26(24%)
Enlightenment	4(7%)	12(22%)	16(15%)
Compensatory	1(2%)	4(7%)	5(5%)
Medical	39(74%)	22(40%)	61(56%)
Totals	53(100%)	55(100%)	108(100%)

Chi Square = 12.97, 3df, p = .0047

Because many women in society are riddled with myths and biases concerning abused women, all of which serve to further victimize battered women, the researcher erroneously assumed that Emergency Department Nurses would prefer an enlightenment model of helping in their practice with battered women. This was hypothesized based on the fact while emergency department nurses often have direct experience with battered women they rarely have had any formal educational preparation on the topic. This lack of knowledge would result in these nurses attributing high responsibility to the woman for her problem of abuse. Since the practice of emergency nursing is deeply rooted in the medical system, a system of care in which the provider solves the patients' problems, it was assumed that emergency department nurses

would attribute low rsponsibility to battered women for solving their problem, thus choosing an enlightenment model of helping. It was interesting to see that while the Emergency Department Nurses did attribute low responsibililty to the woman for problem resolution, they did not blame her, or hold her responsible for her own abuse. This is a particularly encouraging finding and has implications for nursing practice with battered women.

A research finding that was surpising and disappointing was that both groups of nurses in this sample chose the moral model of helping as the second highest model choice. While this model choice holds the woman responsible for her abuse, it also rests on the premise that the woman is also responsible for solving her problem. This orientation is more related to empowerment approaches to working with battered women.

While all respondents chose a medical model in response to the HOT test, direct questioning of the respondents through two short questions on the Educational/Experience Questionnaire (EEQ) demonstrated that the conference attendee nursing sample differed in their attribution of responsibility for being in the abusive situation. When nurses were asked directly whether battered women were responsible for their situation a significant difference between the responses of Emergency Department Nurses and the Conference Attendee Nurses emerged. None of the Conference Attendee Nurses thought that the woman was totally

responsible for her abusive situation while 2 or 4% of the Emergency Department Nurses attributed total responsibility. Forty-five or 78% of the Conference Attendee Nurses thought that the woman was totally not responsible for her abusive situation while only 22 or 39% of the Emergency Department Nurses thought that she was totally not responsible for her abusive situation. The majority of the Emergency Department Nurses, 33 or 58% were neutral on this question.

When asked directly whether they thought that battered women were responsible for getting out of their situation there was no significant differences in the responses between the two groups of nurses. Neither group thought that battered women were not responsible for getting out of their situation. The majority of all the nurses in the sample, 62 individuals or 54.7%, were neutral in their response to this question, but 40% or 45 nurses thought that battered women had high responsibility for getting themselves out of their abusive situation.

The HOT, which asks about behavior and has many more attitudinal items certainly indicated a preference for the medical model for both groups of nurses in this study. However, it is interesting to see that the two sample groups did respond differently on these two general questions concerning attribution of responsibility for problem cause and solution, with the Conference Attendee Nurses attributing significantly

less responsibilty for problem cause (chi square = 18.59, 2 df, p = .0001). Examination of this data in Table 4 demonstrates that there is a significant association between practicing in the emergency department and attribution of responsibility for the abusive situation (chi square = 18.58, 2 df, p = .0001).

Table 4
Chi Square of nurse subjects by scale scores on question 28. Responsibility for the problem

	Nurse Subjects		
Scale Scores	EDN	CAN	Total
Low responsibility (0,1)	22(39%)	45(78%)	67
Middle responsibility (2,3,4)	33(58%)	13(22%)	46
High responsibiliity (5,6)	2(3%)	0(0%)	2
Totals	57	58	115

Chi Square = 18.58, 2 df, p = .0001

In regards to responsibility for problem solution, while there was no significant difference between the groups (Chi square = .25, 2 df , p = .8), it is interesting to note that only 6 subjects in the entire sample, or 5.3% attributed low responsibility for problem solution; 62 or 54.7% were neutral; and 45 or 40% attributed high responsibility for problem solution. This orientation to problem solution is considered characteristic of empowerment approaches to helping. It is also

interesting to see that in regards to these two questions the responses of the Conference Attendee Nurses are more characteristic of the compensatory model of helping in which the woman has low responsibility for problem cause and high responsibility for problem solution. (See Table 5).

Table 5
Chi Square of nurse subjects by scale scores on question 29, Responsibility for getting out of the abusive situation

	Nurse Subjects		
Scale Scores	EDN	CAN	Total
Low responsibility (0,1)	3(5%)	3(5%)	6(5.3%)
Middle responsibility (2,3,4)	30(53%)	32(57%)	62(54.7)
High responsibiliity (5,6)	24(42%)	21(38%)	45(40%)
Totals	57	56	113(100%)

Chi Square = .256, 2 df, p = .88

Hypothesis Two

In helping battered women, nurses who perceive their clinical knowledge level as high on the topic of battered women will prefer a compensatory model of helping more than any other model.

For the entire sample those who perceived themselves as knowledgeable selected the medical model more often than they selected any other model. Therefore this hypothesis is not supported. Of 66 respondents who perceived themselves as knowledgeable, 31 or 47% scored higher on the medical model than any other model. The other models preferred in order of preference were the moral model (18 or 27.3%); enlightenment (11 or 16.7%) and compensatory (3 or 4.5%). Three subjects (5%) who considered themselves knowledgeable did not have a clear preference for any model. Not only was the selection in this order but the mean scores for the scale items were in the same order: medical 27.35; moral 25.36; enlightenment 24.96; and compensatory 22.41.

Other analysis related to level of knowledge and preparation, (questions 24-26 on the EEQ) were performed and will be presented following this section.

Hypothesis Three

In helping battered women, nurses who perceive themselves as well prepared in their practice with battered women will prefer a compensatory model of helping more than any other model.

For the entire sample, those who perceived themselves as well prepared in their practice with battered women selected the medical

model more often than they selected any other model. Therefore this hypothesis is not supported. Of 52 respondents who perceived themselves as well prepared in their practice, 24 or 46.2 % scored higher on the medical model than any other model. The other models preferred in order of preference are for the Moral (14 or 26.9%); enlightenment (9 or 17.3%); and compensatory (2 or 3.4%). Three subjects or 6% who considered themselves well prepared in their practice did not have a clear preference for any model.

Again, not only was the selection in this order but the mean scores for the scale items were in the same order: medical 28.04; moral 26.06; enlightenment 25.31; and compensatory 22.63.

Analysis was also performed on other questions which are components of feeling well prepared in one's nursing practice. These include questions related to nursing role, level of knowledge and preparation, (questions 24-26, 30-31 on the EEQ).

Other Analyses

Part of the nursing role is the display of concern, and a feeling of sadness that abuse is occurring in a woman's life. For this reason a question exploring this dimension of nursing care was included in the instrument. When asked to rate their general feelings towards battered

women, 91 or 80% of the total sample reported great sympathy for battered women, with a mean of 5.08 on a 0-6 point scale. Only 2 subjects, 1.8%, reported no sympathy. Two nurses did not respond. The data also indicated that there exists a significant difference in the amount of sympathy between the two sample groups, with the Conference Attendee Nurses expressing more sympathy (chi square = 6.88, 2 df, p = .03). (See Table 6).

Table 6
Chi Square of nurse subjects by scale scores on question 30, General Feelings Toward Battered Women

	Nurse Subjects		
Scale Scores	EDN	CAN	Total
Great Sympathy (5,6)	40(70.2%)	51(89.5%)	91(80%)
No Sympathy (0,1)	1(1.8%)	0(0%)	1(0.9%)
Neutral(2,3,4)	16(28%)	6(10.5%)	22(19.1%)
Totals	57	57	114

Chi Square = 6.88, 2 df, p = .03

Satisfaction with ones's practice with battered women might be affected by the amount of one's clinical skills and knowledge concerning battered women. This might in turn affect one's response to battered women. A general question eliciting satisfaction with one's practice with battered women was included. The mean for all nurses in the

sample was 3.2 on a 0-6 point scale, indicating no strong feelings on this topic. Only 20 nurses, 17.5% reported being totally satisfied with their practice; 16 or 14% reported low satisfaction; and 78 or 68.5% reported were neutral in regards to satisfaction with their practice with battered women. Two nurses did not respond to this question. There does exists a significant difference in the amount of satisfaction between the two groups, with the Conference Attendee Nurses expressing more satisfaction (chi square = 7.46, 2 df, p = .024). (See Table 7).

Table 7
Chi Square of nurse subjects by scale scores on question 31, Satisfaction With Practice

	Nurse Subjects		
Scale Scores	EDN	CAN	Total
Totally Satisfied (5,6)	5 (9%)	15(26%)	2017.5%)
Unsatisfied (0,1)	11(19%)	5(9%)	16(14%)
Neutral (2,3,4)	41(72%)	37(65%)	78(68.5%)
Totals	57	57	114

Chi Square = 7.46, 2 df, p = .024

The components of satisfaction with nursing practice include an adequate knowledge base and sufficient clinical skills to assess clients and provide effective intervention. Questions were included in the EEQ

which asked subjects are to rate these areas on a 0-6 point scale, with 0 being low and 6 being high. Results indicated that Conference Attendee Nurses in this study felt to a significantly greater extent that they had sufficient knowledge, could readily identify battered women, and had sufficient clinical skills for intervention. Tables 8, 9, and 10 present this data.

Table 8
Chi Square of nurse subjects by scale scores on question 24, Readily Identify Battered Women

	Nurse Subjects		
Scale Scores	EDN	CAN	Total
Always (4,5,6)	29(51%)	44(75%)	73 (63%)
Seldom (0,1,2)	10(18%)	7(12%)	17(15%)
Neutral(3)	18(32%)	8(14%)	26(22%)
Totals	57	59	116

Chi Square = 7.43, 2 df, p = .02

Table 9
Chi Square of nurse subjects by scale scores on question 25, Sufficient Knowledge for effective intervention

	Nurse Subjects		
Scale Scores	EDN	CAN	Total
Sufficient (4,5,6)	18(32%)	48(81%)	66(57%)
Insufficient (0,1,2)	24(42%)	4(7%)	28(24%)
Neutral (3)	15(26%)	7(12%)	22(19%)
Totals	57	59	116

Chi Square = 30.8, 2 df, p = .00

Table 10
Chi Square of nurse subjects by scale scores on question 26, Sufficient clinical skills for effective intervention

	Nurse Subjects		
Scale Scores	EDN	CAN	Total
Sufficient (4,5,6)	19(33%)	43(74%)	62(54%)
Insufficient (0,1,2)	18(32%)	5(9%)	23(20%)
Neutral (3)	20(35%)	10(17%)	30(26%)
Totals	57	58	115

Chi Square = 19.96, 2 df, p = .00

One of the questions that provided data with direct implication for education was an open-ended question on the EEQ which asked subjects to identify any knowledge or skills they felt they might be lacking. Data from these responses were collapsed into categories. These categories were determined by three nurse readers after having read all responses to the question. Each nurse reader was asked to name seven or eight categories into which all the responses would fit. From all suggestions, seven categories emerged. All responses except four were assigned to the categories by the investigator. These categories were experience; knowledge; assessment skills; intervention skills; counseling skills, referral information, and supportive consultation.

Analysis of responses to this open ended question revealed that the Emergency Department Nurses in the sample expressed to a greater frequency the need for more knowledge and intervention skills than the Conference Attendee Nurses. Table 11 reports these findings.

Table 11

Categories and Frequencies of Knowledge and Skill Deficits

Categories	Frequencies		Total
	EDN	CAN	
Experience	3	12	16
Knowledge	10	5	15
Assessment Skills	3	9	12
Intervention Skills	11	5	15
Counseling Skills	10	10	20
Referral Information	8	7	15
Supportive Consultation	6	4	10
Other	0	3	3
Totals	52	55	107

It was interesting to see that the Conference Attendee Nurses (CAN) cited to a much greater extent the need for experience with battered women as a necessary component to addressing their deficits in knowledge and skills (12). Only three of the Emergency Department Nurses (EDN) reported this. This may be explained by the fact that the EDN sample were all currently employed in emergency department settings, where frequent contact with battered women is common. The CAN sample were employed in a variety of settings, including schools of nursing where contact with battered women may be less frequent. These nurses were also employed in ambulatory heath settings and home health

agencies. While battered women certainly present in these settings, their injuries are often less obvious making assessment more difficult. This might also explain the fact that only three of the EDN sample stated the need for assessment skills, as opposed to nine of the CAN sample.

In the intervention category, EDN respondents listed a total of 11 responses. These items focused primarily on skills indicative of wanting to rescue the woman from her situation. These included comments such as: what to say to women to get them talking; what to do to get women to stop denying their abuse; skills to convince women that they need help (4); skills to convince women to take advantage of resources (2); advice to give the abuser; skills important to effect the most change in a brief time. One nurse cited the need for more time to adequately intervene with battered women in the emergency department. The responses in the counseling category (10) were general statements pointing to the need for counseling and psychosocial intervention skills.

Five of the CAN sample cited the generalized need for intervention skills with counseling skills reported by 10 subjects. In addition to general counseling skills, group counseling skills were highlighted in this category by four CAN respondents.

Ten nurses in the EDN sample reported the need for more knowledge on the topic of battering. Comments included the need for a workshop or seminar providing basic information to increase one's knowledge level of

the dynamics of abuse (4); an understanding of the knowledge and skills for effective intervention (3); and knowledge to help understand why women expose themselves to repeated episodes of battering (3). The Can subjects did not express the need for a workshop or seminar, rather they cited knowledge needs related to factual data, up-to-date research on interventions that work, information on feminist therapy and strategies to empower women (2.)

In the referral category, responses from both samples were similar, citing the need for the following items: information on referral resources available (13); information concerning legal referrals (2); and information about the psychological services available to women and men.

Comments were also expressed by both groups that fit into the Supportive Consultation category. The EDN nurses reported the need for help coping with their own feelings about the situation (3); and personal support and understanding. Two male subjects stated that they felt it was difficult for a male nurse to advise on the issue of battering and needed advice on their role. The CAN sample reported similar needs such as help dealing with one's own feelings; help to avoid burnout; skills to remain objective; and help being non-judgemental towards the abuser.

Responses to this open-ended question that could not be accurately categorized were reported by the CAN sample and included the following:

help with language,ethnic and racial barriers; help in dealing with the complexity of the interaction between stigmatization, self blame and blame from others; and application with elder women, including adult son to elder mother abuse.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

Introduction

The purpose of this final chapter is to review and summarize the major findings of the study, to discuss the limitations of the study, and to discuss the implications of these findings for education, practice and future research.

Summary of Major Findings

The purpose of this study was to determine the perceived model of helping preferred by nurses in their interventions with battered women and to determine those factors in the nurses' educational experiences and clinical practice which effect their preference for a specific helping model. The subjects of this study were 116 registered nurses aged 24 to 59; 57 nurses practiced in the emergency department setting, and 59 nurses did not practice in the emergency department setting but had attended a three day national nursing conference on violence against women.

The data of this study were collected through self-administered questionnaires. Descriptive statistics and the results of chi square tests to determine significance were used to respond to the research questions and the hypotheses of the study. The research questions and hypotheses of the study are summarized in Table12.

Table 12

Research Questions and Hypotheses

Questions	Hypotheses
1. What is the helping orientation of nurses toward battered women?	In helping battered women, Emergency Department Nurses will prefer an enlightenment model of helping more than any other model.
2. What is the relationship between specific education on the topic of battering and the helping orientation of nurses towards battered women?	In helping battered women, nurse who perceive their clinical knowledge level as high on the topic of battered women will prefer a compensatory model of helping more than any other model.
3. What is the relationship between clinical experience with battered women and the helping orientation of nurses toward battered women?	In helping battered women, nurses who perceive themselves as well prepared in their practice with battered women will prefer a compensatory model of helping more than any other model.

Table13 reviews the hypothesis testing results of this study. As can be seen, all nurses in this study preferred the medical model of helping over any other model of helping when asked to apply this instrument to battered women receiving help.

Table 13

Hypotheses Testing

Questions	Hypotheses
hypothesis #1 In helping battered women, Emergency Department Nurses will prefer an enlightenment model of helping more than any other model.	Rejected Emergency Department Nurses preferred a medical model of helping over any other model of helping.
hypothesis #2 In helping battered women, nurses who perceive their clinical knowledge level as high on the topic of battering will prefer a compensatory model of Helping more than any other model.	Rejected All nurses in this study preferred a medical model of helping over any other model of helping.
hypothesis #3 In helping battered women, nurses who perceive themselves as well prepared in their practice with battered women will prefer a compensatory model of helping more than any other model.	Rejected All nurses in this study preferred a medical model of helping over any other model of helping.

The results of this study indicate that the medical model of helping, in which the client is attributed low responsibility for problem cause and low responsibility for problem solution, is characteristic of the helping orientation of all nurses in the study sample. This is true regardless of practice setting, or whether or not nurses have acquired specific knowledge on the topic of battering. The medical model, which is characteristic of the direction and focus of the traditional health care delivery system, appears to be highly influential in the practice of nursing with battered women.

A disappointing finding was that in both samples the second choice of model of helping was the moral model. In this model the client is attributed high responsibility for the problem and high responsibility for the solution. It may be that cultural stereotypes concerning women's roles and behaviors as well as societal myths surrounding woman abuse are deeply rooted within most members of American society, hence the preference for the moral model. In another light, this model may have been selected as it assumes that the battered women has some responsiblity for solving her problem. When asked directly about responsibility for problem solution on the Educational/Experience Questionnaire (EEQ), the majority of the nurses in the total sample were neutral on this question, with only five per-cent attributing low

responsibility to battered women. It must also be noted that the low reliability estimates obtained for the compensatory model may limit its usefulness, explaining why nurses might chose the moral model over the compensatory model when attributing high responsibililty for problem solution.

Assumptions underlying this study were that while Emergency Department Nurses had frequent contact with battered women they rarely have any specific knowledge on this topic. This assumption was validatd by the results of the study which indicated that the overwhelming majority of Emergency Department Nurses reported clinical and personal contact with battered women but very few reported having acquired any specific education on the topic of battering. What was cited as the primary source of information on battering were lay publications, popular books, movies and television and contact with the women themselves.

A second assumption underlying this study was that nurses who have acquired specific knowledge on the topic of battering would perceive themselves as knowledgeable and well prepared in their practice with battered women. This assumption was also supported. When asked direct questions on the EEQ aimed at eliciting information about perception of knowledge level and clinical skills, the Conference Attendee Nurses

reported higher levels on all these scales than the Emergency Department Nurses in this study.

However a third assumption of the study, that nurses who perceive themselves as knowledgeable and well prepared in their practice with battered women would prefer a compensatory model of helping was not supported. It was assumed that the acquisition of specific knowledge on the topic of battering would result in the nurse attributing low responsibility to the problem, hence not blaming the victim, and high responsibility for problem solution, thereby empowering the woman to make her own decisions. Instead all nurses choose the medical model of helping. However, when asked direct questions on the EEQ aimed at eliciting information about responsibility for problem cause and solution, the Conference Attendee Nurses attributed significantly less responsibility for the cause of the problem than the Emergency Department Nurses in this study.

In regards to clinical practice with battered women, this study clearly documents that the nurses in this sample have significant contact with battered women in both the clinical and personal setting. The results also demonstrated that18% of the entire sample reported that they themselves had been abused. This provides further information documenting that violence against women occurs in all ethnic and

socio-economic categories. The study also indicated a high level of nursing intervention with battered women, as 75% of the total sample reported that they intervened clinically with battered women. An important finding of this study was the high degree of sympathy expressed by all nurses towards battered women, with 80% of the total sample reporting sympathetic feelings. Of interest is that the conference Attendee Nurses reported significantly more sympathy than the the Emergency Department Nurses in this study.

Limitations of the Study

The limitations of this study include the fact that this was a non-random sample and that the sample was moderate in size. Another limitation of this study may be that the measure chosen to examine the helping orientation of nurses, the dependent variable, (measured by responses on the HOT), may restrict the extent to which these results can be interpreted. The reliability coefficients on all model scales were low with the Medical Model approaching the highest reliabililty estimate (.63). Many subjects provided comments on the instrument which indicated their uneasiness with the response stems. This may have affected their ability to answer the item in an accurate fashion. It may

be that another tool should be developed to measure the variable of helping more sensitively with a nurse population.

Implications

Education

This study certainly points to the need for more specific educational strategies to improve the knowledge and clinical skills of nurses in their work with battered women. Only 20% of the total sample had obtained any information on this topic in their basic nursing education program. While the Conference Attendee Nurses did report acquiring information in subsequent educational degree programs and conferences, only a few of the Emergency Department Nurses reported this. In response to an open-ended question asking for knowledge and skills needs, the Emergency Department Nurses reported to a greater degree the need for more knowledge. In particular they cited the need for workshops and seminars on this topic.

Practice

This study certainly documents that nurses come in direct contact with battered women and provide clinical intervention with these women.

Satisfaction with practice, level of knowledge and perceived sufficiency of clinical skills were higher in the Conference Attendee Nurses. This has importance for clinical practice as it demonstrates that nurses who possess some specific education on the topic of battering in this study did rate themselves higher even though they reported a higher frequency of responses which stated the need for more direct experience with battered women.

Another finding of this study was that nurses in both samples reported the need for supportive consultation to enhance their practice with battered women. This indicates that knowledge and skills may not be adequate; support and clinical consultation is also important for on-going practice with battered women.

Future Research

This study could be replicated with larger sample sizes, random samples, and samples which include nurses who practice in a variety of clinical settings. It might also be interesting to repeat this study with Physicians to see if they also prefer a medical model of helping and to examine their direct attributions, educational experiences, and perceived level of knowledge and skills.

Conclusion

This research investigated factors which influence the helping orientation of nurses in their practice with battered women. An examination of the model of helping perferred by nurses with battered women was chosen as a method of understanding how nurses approach their practice with battered women. Knowledge about the helping orientation of nurses can influence efforts aimed at changing the practice of nursing through changes in education as well as focusing further research in this area. Research in the health care domain can provide another link in our efforts to eliminate violence against women and provide effective intervention to its victims.

Appendix A

The Education/Experience Questionnaire

THE EDUCATION/EXPERIENCE QUESTIONNAIRE

1. Sex
   1) Female _____ 2) Male _____

2. Age _____

3. Ethnic group
   1) White _____ 4) Asian _____
   2) Black _____ 5) Other (specify): _____
   3) Hispanic _____

4. Marital status
   1) Single _____ 4) Separated _____
   2) Married _____ 5) Widowed _____
   3) Divorced _____

5. Basic Nursing Education
   1) Associate degree _____ 3) Diploma _____
   2) Baccalaureate degree _____ 4) Other (specify): _____

6. Year of graduation from basic program _____

7. Indicate the highest degree you have earned
   1) Baccalaureate in nursing _____
   2) Baccalaureate in other field (specify): _____
   3) Master's in nursing _____
   4) Master's in other field (specify): _____
   5) Ph.D. in nursing _____
   6) Ph.D. in other field (specify): _____
   7) D.N.Sc., D.N.S., D.N. _____
   8) Ed.D. _____

8. Year of graduation from highest degree _____

9. Years experience in Nursing
   1) Less than one year _____ 4) 11-15 years _____
   2) 1-5 years _____ 5) 15-20 years _____
   3) 6-10 years _____ 6) More than 20 years _____

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(Continued)

10. Current practice setting
    1) emergency room _____
    2) community/home health _____
    3) school of nursing _____
    4) H.M.O./Ambulatory _____
    5) staff development _____
    6) psychiatric _____
    7) hospital _____
    8) nursing home _____
    9) administration _____
    10) other (specify): _____

11. Years in current practice setting
    1) Less than one year _____
    2) 1-5 years _____
    3) 6-10 years _____
    4) 11-15 years _____
    5) 15-20 years _____
    6) More than 20 years _____

12. Most recent past practice setting
    1) emergency room _____
    2) community/home health _____
    3) school of nursing _____
    4) H.M.O./Ambulatory _____
    5) staff development _____
    6) psychiatric _____
    7) hospital _____
    8) nursing home _____
    9) administration _____
    10) other (specify): _____

13. Years in most recent past practice setting
    1) Less than one year _____
    2) 1-5 years _____
    3) 6-10 years _____
    4) 11-15 years _____
    5) 15-20 years _____
    6) More than 20 years _____

14. Was information about battered women included in your basic nursing curriculum? yes _____ no _____
    If yes, then estimate how many hours were spent on this topic. _____

15. Was information about battered women included in any other degree program? (please specify) yes _____ no_____

    _____

    _____

    If yes, then estimate how many hours were spent on this topic. _____

(Continued on next page.)

(Continued)

16. Have you obtained information about battered women in any of the following ways. Check as many as apply.
    specific workshop or conference on battering _____
    1-3 hour session on battering _____
    books or journal articles _____
    newspaper or magazine articles _____
    films and television _____
    other (please specify) _____

17. Where do you think that you have obtained the most useable information about battered women?

    _____

    _____

    _____

18. In your nursing practice do you come in contact with clients who are battered women? yes _____ no _____

19. Have you intervened clinically with battered women around the specific issues of battering? yes _____ no _____

20. If yes, then on the average how many women per month do you encounter. _____ Or if this is not possible than how many per year._____

21. For how many years has your nursing practice included helping battered women. _____

22. Have you personally known any battered women? Check all of the following which apply, and if more than one please indicate the numbers.
    friends _____
    neighbors _____
    co-workers _____
    relatives _____
    sisters _____
    mother _____
    daughter _____

(Continued on next page.)

(Continued)

23. Are you currently or have you ever been involved in an abusive relationship as an adult with an intimate partner?
yes _____ no _____
If yes, for how many years? _____

If you would like to discuss this in writing please feel free to write on the back of this questionaire.

24. In your practice setting do you think that you can readily identify women who are battered.

seldom----------always
0 1 2 3 4 5 6

25. Do you think that you have sufficient knowledge about battering to intervene effectively with battered women.

insufficient ----------sufficient
0 1 2 3 4 5 6

26. Do you think you have sufficient clincial skills to assess and provide effective intervention with battered women.

insufficient ----------sufficient
0 1 2 3 4 5 6

27. What knowledge or skills, if any, do you feel that you may be lacking?

_____
_____
_____
_____
_____
_____

(Continued on next page.)

(Continued)

28. Do you think battered women are responsible for their abusive situation?

not responsible ----------totally resonsible

0 1 2 3 4 5 6

29. Do you think battered women are responsible for getting themselves out of their abusive situation?

not responsible ----------totally responsible

0 1 2 3 4 5 6

30. In general what are your feelings towards battered women.

no sympathy ---------- great sympathy

0 1 2 3 4 5 6

31. Are you satisfied with your practice with battered women?

unsatisfied ----------totally satisfied

0 1 2 3 4 5 6

Appendix B

Help Orientation Test

HELP ORIENTATION TEST

Please respond to the following questions about helping. When you think of help or persons who need help try to think of **battered women**. I know that not all battered women are the same but they do share some characteristics in common. Please answer **all** the questions and give your immediate response even though they may seem strange to you.

Rate how true you feel each of the following statements is. If a statement is not at all true, circle 0. If a statement is completely true, circle 6. If a statement is somewhere in between not at all true and completely true, circle the number in between 0 and 6 that best represents how true it is.

Battered Women Receiving Help:

1. Need to see that they are not alone
   not at all true 0 1 2 3 4 5 6 completely true

2. Need the fair chance they have so far been denied
   not at all true 0 1 2 3 4 5 6 completely true

3. Need only to be shown how to improve
   not at all true 0 1 2 3 4 5 6 completely true

4. Need therapy
   not at all true 0 1 2 3 4 5 6 completely true

5. Are deprived
   not at all true 0 1 2 3 4 5 6 completely true

(Continued on next page.)

(Continued)

Battered Women Receiving Help:

6. Are stubborn

not at all true 0 1 2 3 4 5 6 completely true

7. Are ill

not at all true 0 1 2 3 4 5 6 completely true

8. Are unaware

not at all true 0 1 2 3 4 5 6 completely true

9. Need something like a doctor

not at all true 0 1 2 3 4 5 6 completely true

10. Need something like a friend

not at all true 0 1 2 3 4 5 6 completely true

11. Need something like time to think

not at all true 0 1 2 3 4 5 6 completely true

12. Need something like a tutor

not at all true 0 1 2 3 4 5 6 completely true

13. Would become increasingly self destructive if they did not get help

not at all true 0 1 2 3 4 5 6 completely true

14. Would be all right even if they did not get help

not at all true 0 1 2 3 4 5 6 completely true

15. Would become increasingly sick if they did not get help

not at all true 0 1 2 3 4 5 6 completely true

(Continued on next page.)

(Continued)

Battered Women Receiving Help:

16. Would become hostile or violent if they did not get help
not at all true 0 1 2 3 4 5 6 completely true

17. Need help to be given for a fixed, temporary period
not at all true 0 1 2 3 4 5 6 completely true

18. Need help to be given until they are cured
not at all true 0 1 2 3 4 5 6 completely true

19. Need a long term relationship with someone who has had similar experiences
not at all true 0 1 2 3 4 5 6 completely true

20. Need only to get themselves together and discover where they personally want to go
not at all true 0 1 2 3 4 5 6 completely true

21. Will fail unless they accept guidance from those who have "been there"
not at all true 0 1 2 3 4 5 6 completely true

22. Will fail unless they are completely self reliant
not at all true 0 1 2 3 4 5 6 completely true

23. Will fail unless they are given the resources they deserve
not at all true 0 1 2 3 4 5 6 completely true

24. Will fail unless those helping them are skillful enough
not at all true 0 1 2 3 4 5 6 completely true

(Continued on next page.)

(Continued)

Battered Women Receiving Help:

25. See helpers as people who enjoy seeing justice done

not at all true 0 1 2 3 4 5 6 completely true

26. See helpers as people who enjoy doing a job for which they are highly respected

not at all true 0 1 2 3 4 5 6 completely true

27. See helpers as people who enjoy giving advice on how to cope

not at all true 0 1 2 3 4 5 6 completely true

28. See helpers as people who enjoy discovering a new "brother" or "sister"

not at all true 0 1 2 3 4 5 6 completely true

29. Need to reorient themselves and get back on their feet

not at all true 0 1 2 3 4 5 6 completely true

30. Need experienced, trained care

not at all true 0 1 2 3 4 5 6 completely true

31. Need to dedicate themselves to a higher cause

not at all true 0 1 2 3 4 5 6 completely true

32. Need the resources of those more fortunate

not at all true 0 1 2 3 4 5 6 completely true

33. Without help, would withdraw and fall apart

not at all true 0 1 2 3 4 5 6 completely true

(Continued on next page.)

(Continued)

Battered Women Receiving Help:

34. Without help, would seek a means to success that society might not approve

not at all true completely true

0 1 2 3 4 5 6

35. Without help, would pursue the illusion that they can do everything by themselves

not at all true completely true

0 1 2 3 4 5 6

36. Without help, would miss the discovery of their deepest inner stregnth

not at all true completely true

0 1 2 3 4 5 6

37. Will need help again only if they fall sick again

not at all true completely true

0 1 2 3 4 5 6

38. Will need help again as a matter of being part of a community

not at all true completely true

0 1 2 3 4 5 6

39. Will need help again only as a reminder that they are responsible for themselves

not at all true completely true

0 1 2 3 4 5 6

40. Will need help again only if a further unfairness occurs to them

not at all true completely true

0 1 2 3 4 5 6

Thank you very much for taking the time to answer this questionnaire.

Appendix C

Letter of Introduction to Nurse Managers

Dear (Nurse Manager),

Thank you very much for considering my request to conduct an study examining the helping orientation of nurses toward battered women. I am a faculty member in the Division of Nursing and a doctoral candidate in the School of Education at the University of Massachusetts in the process of dissertation research.

To complete the requirements for my doctoral degree I am requesting permission to distribute questionnaires (to the Emergency Department Nurses at your hospital). Enclosed is a complete copy of my dissertaton proposal which has been approved by the School of Education Dissertation Committee and the Human Subjects Review Committee.

Subjects participating in this study will be asked to respond to two questionnaires designed to examine the relationship between education and clinical experience and the perceived model of helping employed by nurses in their interactions with battered women.

As discussed on the phone, I have enclosed copies of the questionnaires which take approximately 15 minutes to complete. Participation is voluntary, all responses are anonymous, and their are no attendent risks expected. If approved, these questionnaires (can be distributed to the emergency department nurses' at your earliest convenience or will be mailed to the conference attendees). I will provide self-addressed, stamped envelopes for their return and a summary of the findings may be obtained upon request.

I shall be calling you in one week to discuss this research request and answer any questions you may have.

Sincerely,

Christine King R.N., M.S
Division of Nursing
University of Massachusetts
Amherst, MA 01003

Appendix D

Letter of Introduction to Participants

Dear Colleague:

To complete the requirements of my doctoral program in School, Consulting, and Counseling Psychology in the School of Education at the University of Massachusetts/Amherst, I am conducting a study examining the helping orientation of nurses towards battered women. I am particularly interested in the relationship between education and clinical experience and the model of helping employed by nurses in their interactions with battered women. The results of this study can be useful in developing recommendations and educational programs which assist nurses in meeting the nursing and health care needs of battered women.

Your opinions are very important for this study and I assure you that your responses will be held in strictest confidence. The responses of all individuals will remain anonymous. Your participation is voluntary, with completion of the questionnaire and your signature constituting your informed consent. You are free to withdraw your consent and discontinue participation at any time. There are no attendent discomforts or risks expected. I do hope that you will participate in this study by taking the 15 minutes to express your opinions on the attached questionnaire. When you have completed the study, kindly return the questionnaire, which is already addressed and stamped, to me within one week.

I am aware of the many demands on your time and appreciate your efforts to assist me in this research process. The results of this study will provide another link in our collective efforts to improve the quality of nursing care rendered to battered women and ultimately to help free women from abusive and violent life situations.

If you have any questions, or if you would like to discuss any feelings or reactions which emerged for you in the process of completing this survey, please feel free to call me at home (413-586-6109) or at work (University of Massachusetts/Division of Nursing 413-545-0405). If you are interested in obtaining the results of this study, enclose your name and address or send a separate note or card and I will forward the results to you when this research is completed. Thank you for your time and cooperation.

Sincerely,

Christine King, R.N., M.S.
Division of Nursing
University of Massachusetts

Appendix E

Information and Instructions

QUESTIONNAIRE

This questionnaire will ask you some questions about the nature of help and about the people receiving help. The questionnaire consists of two parts. Part 1 is the **EDUCATION / EXPERIENCE QUESTIONNAIRE**; Part 2 is the **HELP ORIENTATION TEST**. Please complete both parts.

For the purpose of this study **Battered Women** will be defined as:

> women who have been subjected to deliberate and repeated acts of physical and/or psychological violence and abuse by a man with whom she has or has had an intimate relationship.

Helping is defined as:

> an interaction between a person needing help and a person able to give help with the desired outcome of resolving the problem presented by the person needing help.

Instructions:

1. Read each item carefully.
2. Circle the answer that applies most often to you.
3. Write in the appropriate answer in the space available.

I have read the study letter and instructions and voluntarily agree to participate in this study.

Name _____

Date _____

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